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ABSTRACT

Prevention of dental disease is the key to improving the nation's oral health. The American Dental Association (ADA) program of prevention and control of dental disease through improved access to comprehensive care concentrates on those who have special difficulties in receiving care: the poor, the elderly, the handicapped, the institutionalized and the uninsured. An additional group deserving continued attention are those who have access to the system and do not use it. While the dental care delivery system is basically sound, there is a void in financing mechanisms for those unable to pay and a shortage of dentists in isolated areas. The fixed nature of facilities presents problems to those unable to travel. The ADA program stresses increased prevention efforts within the profession and public sector, including government, and explores the possibility of broader health care funding. Tables, figures, charts, and the appendices contain the statistical data for this report. (JAC)

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AMERICAN DENTAL ASSOCIATION

PREVENTION AND CONTROL OF DENTAL DISEASE THROUGH IMPROVED ACCESS TO COMPREHENSIVE CARE

CG 015986

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PREVENTION AND CONTROL OF DENTAL DISEASE THROUGH IMPROVED ACCESS TO COMPREHENSIVE CARE

PART I: INTRODUCTION

Background: At its December, 1978 meeting, the Board of Trustees approved a resolution, offered by the trustee of the Eighth District, Dr. Robert H. Griffiths, directing that a review be undertaken of activities concerning one aspect of dental care delivery, that a report be made on the accomplishments of these activities and that recommendations be given as to further steps that should be taken.

At the same meeting, the Board undertook exploration of a proposal by the trustee of the Sixth District, Dr. Joseph H. Hagan, of a *Total Plan for Dental Disease Control by the Year 2000.*

At its March, 1979 meeting, the Board received a plan, *War on Tooth Loss*, developed by Dr. Arthur L. Labelle, a member of the Council on Prosthetic Services and Dental Laboratory Relations.

The concern behind these suggestions is, the Board believes, one that is shared by dentists throughout the nation.

It is a concern that the Association seize the initiative with regard to the further improvement of the dental health of the nation. It is a concern that the Association show conclusively that the profession's policies and programs are better designed to serve the dental health needs of the American people than are those of any other group. It asks the Association to use its resources vigorously to demonstrate how dental disease can be prevented and controlled. It calls upon the Association to speak forcefully not just about the dentist's responsibilities but also those that must be shouldered by society as a whole, by government and by the individual. Finally, it expresses a concern that the Association be the first to recognize any shortcomings of the existing dental care delivery system and come forward with solutions to them.

The initiatives offered by Drs. Griffiths, Hagan and Labelle are, in this respect, symbolic of the profession's determination to continue as a major, visible force in the setting of dental health policies and practices in the United States.

Purpose of Report: In its meetings since the 1978 annual session, the Board has spent much of its time in discussing how best to meet this evident and valid concern. This report is the synthesis of those long hours of deliberation. It draws freely upon insights offered by many members of the profession.

The fundamental thrust of this program—prevention and control of dental disease through improved access to comprehensive care—is to stress the capability of the profession to provide a level of oral health care unsurpassed anywhere in the world. By concentrating primarily on those fellow citizens who have special difficulties in receiving care, it can help validate the flexibility and reach of the traditional dental care delivery system. It can, in addition, clearly delineate the obligations that are those of the profession and those responsibilities that others, finally, must be willing to undertake. It can, as well, demonstrate the Association's continued willingness to take a fresh look at suggestions for improvement of dental health and to judge such suggestions on the basis of their merit.

Relationship to Other Programming: While this new activity will represent a major undertaking of the Association, it will not be the sum total of all Association programming. At the same time as this initiative on prevention and delivery of care is launched, it is imperative that attention continue to be given to such present efforts as those regarding professional education, basic and applied research and oral health education of the public. In many instances, specific efforts in such areas as these will relate to the effort to prevent and control dental disease through improved access to comprehensive care. It will be the responsibility of the Executive Director, as well as the Board of Trustees, to assure efficient coordination of this program both of itself and as it relates to all Association activities.

Intended Actions: In this regard, three points should be apparent. The first is that all the actions the Board intends to take, which are listed within the body of the Report, accord with present policy of the Association. That this should be so is a striking instance of the foresight with which the House has set policy. In specific instances, all of which are noted, the Board is exploring the continued validity of particular policy, a necessity for any organization that hopes to remain vital. No actions will be taken, of course, except in strict compliance with present policy. If the Board determines that any policy change is needed, it will come to the House for approval in the usual way.

Secondly, the actions to be taken by the Board are stated in broad terms. Association agencies will develop detailed program proposals and estimates of the needed resources.

Thirdly, the 1980 operating budget being submitted to the House has only a modest amount of money directly tied to this program. The Board fully expects this to be supplemented by funds elsewhere in the budget for activities in accord with the purposes of this program. In addition, the Board will, if necessary, consider using the existing contingent fund to guarantee that the program is properly supported during 1980.

Use of Term "Access": In framing this program, the Board is mindful of the fact that the term "access" has, in some areas of the country, a narrower meaning than the one

applied to it in this program. The word is, however, the simplest and clearest one in the English language to denote what is meant. It means the opportunity for each individual to enter into the dental care system and to make use of dentists' services as the best way of preventing and controlling oral disease. The decision to actually use the system is, of course, that of the individual. However, it is the obligation of all society—and a major purpose of the profession—to insure that this opportunity exists. It is the obligation of all society—and a major purpose of the profession—to be sure that the system offers genuine access to everyone, even those whose circumstances of life pose greater difficulties than normal in seeking and receiving dental care.

Reason for Submission to House: Since this report contains no new policy recommendations, it is submitted to the House for its information. It is, however, so major an undertaking that the Board believes special attention should be called to it. In doing so, the Board asks the House's advice. To facilitate this, the President of the Association has established a special Reference Committee during the 1979 ADA Annual Session. The Board will be most attentive to counsel offered by this Reference Committee and House of Delegates.

Shared Responsibility: In reviewing this report, the Board is confident that the House shares its view that the prevention and control of dental disease have always been fundamental objectives of this Association. An essential aspect of the *Object* of the Association is to encourage the improvement of the health of the public.

With respect to delivery of care, genuine access to the system is fundamental. Unless the individual has the opportunity to obtain dental care regularly, there is little hope that he or she will enjoy good oral health.

No one has done more than the dentist—individually and within his professional societies—to assure such access. Yet today not every American has the opportunity to receive the care the public and dentists would wish.

Dentists cannot remove the remaining barriers single-handedly. Indeed, if that had been possible, dentists would have already done so. It is a shared responsibility. It is one in which other elements of society and the individual must be willing to play their role more fully than they have before.

Nonetheless, it is well within the traditions of the profession to be willing to take the first steps; to focus on remaining problems and to recommend appropriate solutions to them. And it is within that tradition that the Board intends to carry out this program of prevention and control of dental disease through improved access to comprehensive care.

PART II: OVERVIEW

Intent: This section of the report comments on the general role of organized dentistry in enhancing the opportunity for dental care and, as well, discusses those circumstances of life that, whenever they occur, hinder access. The section has appended to it, as do all subsequent sections, a series of actions that the Board proposes to take to achieve given objectives.

The sections of the report following this one concentrate on particular groups for whom special attention is desirable. These are: the poor and working poor; the elderly; the remote area resident; the handicapped, institutionalized and homebound; and the worker without dental prepayment coverage.

These are, of course, broad categories. An individual may well have characteristics that place him in more than one category. This approach permits, however, an orderly process of examination of the way in which access can be enhanced relative to each identifiable barrier being considered.

Many Americans who fit into these categories now have ample access to care and are availing themselves of it. But, again, the intent of this program is to assure that every American who suffers from one or more of these objective barriers to full access—such as poverty or developmental disability—be given special attention.

Further, there is an additional group of people who, while not the specific subject of this report, deserve continued attention. They are the millions of Americans who have full access to the system but who make only intermittent use of it and, as a consequence, suffer from unnecessary dental disease. Some of the activities of the Public Education Program, as well as aspects of the Association's traditional communications and oral health education activities, are addressed to this group. Such programs will continue as necessary and will be coordinated as appropriate with this undertaking on access.

Prevention and Control of Disease: It cannot be said too often that prevention of dental disease is the key to improving the nation's oral health. Prevention requires the individual to participate actively in a sensible oral health program. Every step taken in implementing a program of improved access will stress the paramount importance of prevention and the necessity for the individual to accept a significant degree of personal responsibility for his or her dental health.

Within the profession there is general agreement that sufficient scientific knowledge and technology exist to control dental disease. Accordingly, for many years the Association has made the prevention and control of dental disease one of its primary objectives. The realization of this objective has been impeded by a number of problems in communication and human behavior. While the profession is well on its way to accomplishing needed changes within the profession in areas directly within its control, concerns outside the profession also need to be addressed. For example, government health leaders have not made the prevention of dental disease a high

priority. As a result, too little has been done to include preventive dentistry in local, state and federal public health programs.

The Board is of the opinion that government at all levels should play a greater role in educating the public to the preventable nature of dental disease and to the collaborative efforts and shared responsibilities of the public and the profession. As an example, every effort must be undertaken by the Association and government to promote universal use of fluoridated water, a public health program long recognized as one of the most cost-effective preventive health measures available to man.

Additionally, the Board believes a greater effort should be made to encourage administrators of dental health plans to include preventive procedures in basic coverage.

As a part of this proposed access program, the Board believes the profession should increase its collaborative efforts with those agencies outside the Association to emphasize the need for making the prevention and control of dental disease a high priority and believes this renewed activity should start with a program to:

—encourage health planners at all levels of government to adjust their priorities to provide first-dollar funding for prevention activities, including funding for broad-based health education programs, patient education and early screening and referral programs;

—encourage health leaders, both providers and planners, to work toward increased funding for behavioral science programs designed to study behavior modification, especially with respect to patient motivation, patient education and acceptance of proven public health measures such as fluoridation;

—encourage administrators of third party health plans to include dental care benefits and to include preventive procedures in basic coverage.

Previous Accomplishments: This program is squarely addressed to the question of what more the profession can do, beyond its present efforts and accomplishments, to improve access to care. This discussion, however, must take place within the context of the Association's long record of substantial accomplishment. While it would serve no useful purpose to discuss them in detail, some of the more prominent efforts should at least be noted in the interest of providing a fair and balanced picture:

—fluoridation of community water supplies;

—a series of national dental health programs for children;

—support of the Health Professions Placement Network;

—cooperative support, through grants to the National Foundation of Dentistry for the Handicapped, for projects throughout the nation caring for more than 10,000;

—expansion of duties of dental hygienists and dental assistants;

—encouragement of and cooperation with private group dental prepayment and quality assurance programs;

—extensive efforts to include dental care for children within Medicaid;

—support since 1977 for inclusion of dental benefits under Medicare;

—objective, publicly available statistics and supplementary interpretation on the world of dentistry and dental practice;

—support of funding from the public sector for the dental education system;

—cooperation with the new health planning organization;

—support of basic and applied research designed to improve the quality of care;

—enactment of *Guidelines for Dentistry's Position in a National Health Program.*

Assumption: In framing this program, the Board has acted upon a number of assumptions it believes are shared by most members of the profession. These provide much of the rationale for this undertaking. These assumptions are that:

—prevention of dental disease must continue to be stressed in all Association programs;

—the total dental health needs of the individual must always be taken into account;

—the traditional form of private practice remains the central source of dental care for Americans but other forms of practice represent an additional resource of the dental care delivery system;

—dentists in practice, in public health, in research and in education all have valuable experience and insights that should be freely shared;

—the present system has ample capacity to care for more patients. The experience in areas where massive prepayment coverage began helps demonstrate this;

—there is sufficient flexibility within the dental school and auxiliary education programs to produce required manpower when needed;

—sufficient information and resources are available to launch this program now, leading to the fullest possible opportunity for dental care for every American.

Policy on National Health Insurance: In the context of this proposed access program, it is important to consider the Association's policy regarding national health insurance (NHI). As mentioned elsewhere in this report, all recommended actions are in concert with existing policy. One of the fundamental principles embodied in the Association's NHI guidelines is that the dental profession is dedicated to pursue efforts to ensure that sufficient dental care services are available to meet the demand of the American people, thereby providing access to all.

Other principles are also in harmony with the actions proposed in this report. These include: the participation

of the profession in the development of public programs which include dental care; recognition of the traditional form of private practice as the major source of delivering care; and the belief that the use of public funds should be limited to the provision of care to those financially unable to pay for services themselves.

With respect to these principles, and all others, the Board believes this program is designed in such a way that it will retain its effectiveness irrespective of changes in national health policy or in the form taken by proposals for national health insurance. In its legislative activities, of course, the Association will continue to urge adoption of its policies with respect to these matters.

Public Education: The access program may open wide the doors of entry into the dental delivery system, but unless ingrained, socioeconomically based attitudes are somehow removed, few new people will enter the system. As a result, the ultimate goal of increased access—improvement of the nation's dental health—will not be realized. For this reason, an intensive public education effort is integral to the success of the program. Through coordinated communications initiatives, the Association will attempt to gain public and key target group support for the access program. It will also attempt to encourage the access program population groups to seek regular, preventive care, as well as initial restorative services.

Motivational Aspects: The issue of prevention and control of dental disease through improved access to comprehensive care includes another essential understanding. While typically access program considerations focus on finance, geography, convenience and ability to receive care, it is conceded that there are other factors which affect a significant segment of the population. Frequently, individuals who require dental service will not be motivated to seek care even though convenience, geography and cost are not major barriers for these people. There are motivational and psychological considerations which have varying effects on all segments of the population. It is agreed that a major emphasis of future Association study regarding the implications of a comprehensive access program must include an objective analysis of motivational and psychological factors as barriers to receiving care.

The Dental Care Delivery System: The dental care delivery system that exists in the United States is as sound as any that has existed at any time in history. It annually serves more than 100 million Americans. As in all health delivery systems, however, there is room for improvement. Following are three aspects of the current dental delivery system that deserve special consideration:

Void in financing mechanisms for those unable to pay for care: The current system is largely based on the premise that dental care is a private matter between the dentist providing that care and the patient recipient. If, however, the patient does not have the money necessary to pay fairly for that service, and if the patient is not covered by prepayment, then in most areas, there is a void created which is aggravated by the current deficiency in Medicare and Medicaid. Since 1965, Medicaid and Medicare have existed as mechanisms designed precisely to fill that void in the health care system—except for dental care. Medicaid and Medicare as presently constituted and operated are largely irrelevant to the dental patient and there is no alternate mechanism that applies. Therefore, the patient either has the potential financial resources or the dentist provides the care as a charity. As a matter of fact, there is clear evidence that dentists do provide a significant amount of care to disadvantaged populations with reduced charge or without any charge. Admittedly, this is not a long-term solution and society is not fulfilling its obligations by providing a realistic mechanism to the patient who cannot afford to receive dental care services.

Shortage of dentists in some isolated areas: Whether there are too few or too many dentists nationally has no relevance to the fact that there are still communities in the United States where reasonable access to regular dental care is wholly or largely unavailable. The issue of providing regular dental care to remote and isolated areas of the country must be considered as a major item of Association programming.

Fixed nature of facilities: Persons who are able to travel to a source of care are better served by the dental delivery system than those who must have care brought to them. The latter category includes many handicapped, homebound and institutionalized persons. In addition, as more people live longer, a new group of persons who are enfeebled by age is being added to this category. No widespread mechanism has yet come into place to solve this growing problem.

None of the above is insurmountable nor does any condemn the present system. They are, however, important issues that need to be studied and remedied. At pertinent points within this report, actions to overcome these problems will be stated. With respect to the points raised in this section of the report, the Board intends to take the following actions:

1. INCREASE ASSOCIATION EFFORTS TO PROMOTE THE CONCEPTS OF PREVENTION WITHIN THE PROFESSION AND THE PUBLIC SECTOR, INCLUDING GOVERNMENT.

Rationale: Although widely acknowledged within the profession, the benefits of prevention must continually be promoted to individual dentists and the public. The Association cannot rely on past initiative to carry this message forward.

Current emphasis on the promotion of fluoridation by adding staff expertise and expanding services to state dental societies must be maintained. The Association must work closely with the government to facilitate coordination of effort at the local level.

The Association must persuade government of its major role in educating the public about prevention and oral health.

Efforts aimed at patient education must be evident in all dental prepayment programs including government programs.

2. DRAW FREELY ON THE SPECIAL PROFESSIONAL ABILITIES OF DENTISTS WHO ARE EXPERT IN PRACTICE, IN PUBLIC HEALTH, IN RESEARCH AND IN EDUCATION.

Rationale: The dentists of the nation are the richest resource upon which the Association can rely. It is the belief of the Board that the diversity of expert knowledge within the profession is equal to the complexity of a program such as this. Clearly, the private practitioners of the nation are a major source of help. So, too, are those who have devoted their professional careers to public health, research and education and those who have actively studied dental delivery and practice configurations.

It is the Board's intention to ask Association agencies to examine their use of consultants in order to assure that we are reaching out to all who should be heard. The Board will request all Council chairmen to help guarantee that agencies of the Association with similar interests will share consultants and expertise and work jointly in the development of these priority programs.

3. ACTIVELY SEEK ALLIES THROUGHOUT SOCIETY ON SPECIFIC ACTIVITIES THAT WILL HELP IMPROVE ACCESS TO CARE FOR ALL.

Rationale: In the Board's opinion, many of the goals to be pursued within this program cannot be achieved without active assistance from other groups and individuals within society. This clearly is a lesson to be drawn from the difficulties encountered in such efforts as extending fluoridation nationally, providing greater fiscal support for dental care of the poor or achieving amendment of Medicare to include dental benefits. In serving the public and its members, one obvious role of the Association is to engage the attention and understanding of other elements within society about dental health problems and cooperatively work toward a solution.

The Board includes among such potential allies other national dental organizations, nondental private groups and public bodies.

In seeking such case-by-case alliances, the Board intends to vigorously urge the Association's point of view while being attentive and sympathetic to the strongly held views of others. There is, the Board believes, considerable opportunity for fruitful negotiation without any compromise of fundamental tenets of the profession.

4. MAINTAIN AND COORDINATE COUNCIL AND OTHER ASSOCIATION ACTIVITIES INVOLVED IN THIS PROGRAM.

Rationale: This program will represent a major element of Association programming. Association agencies without exception will be requested to scrutinize their *Bylaws* responsibility in light of it and to adjust programming as desirable to assist in the success of the program. Additionally, as noted, the Executive Director will take all appropriate steps to assure interagency coordination of effort.

At the same time, a number of other activities not centrally part of this program are essential and will be continued. There will be occasions when other activities will mesh with those encompassed within this program. It may be, for example, that aspects of the dental curriculum at both the undergraduate and advanced levels might need to be adjusted to better train dentists to care for special groups such as the handicapped. It may be that a need would become apparent for applied research on new equipment or instrumentation. Progress in continued research on a method to eliminate dental caries would have an obvious impact on the program under discussion here.

This program, then, is intended to strengthen and coordinate many of the efforts of the Association but is not intended to supplant everything the Association presently does.

5. MAINTAIN QUALITY DENTAL CARE IN ALL ASPECTS OF THE DELIVERY SYSTEM.

Rationale: It has always been of the highest importance to the dental profession to demonstrate to patients that the treatment they receive is necessary, appropriate and provided at a high level of quality. It has become even more urgent in recent years to document this standard. The Association has already taken a number of steps in furthering quality assurance. Publication in 1978 of a survey on the state of the art in dental quality assurance is one example, as is the recent creation of a quality assurance study of the Association. Whatever the circumstances under which care is provided, and whoever is being cared for, the Association will continue to insist on a uniform high standard of quality.

6. SEEK NEW WAYS FOR THE ASSOCIATION TO ASSIST STATE AND LOCAL DENTAL HEALTH UNITS TO STRENGTHEN THEMSELVES.

Rationale: It is apparent that the Association cannot of itself guarantee success of this program. For success to be achieved, there needs to be in place throughout the nation dental units that are well-structured and appropriately financed. In the private sector, constituent and component dental societies perform this function. In the public sector, state and local dental health units are most important. In too many cases today, these public units are given scant attention and insufficient funding by the government. In too many cases today, the natural bond between the state and local dental society and their counterpart dental health units is less strong than it

should be. The Board believes it imperative that attention be given to dental public health activities and intends for the Association to play a larger role in this than it has heretofore. The Board will encourage increased cooperation between state dental societies and state dental health departments.

7. SPEAK CLEARLY TO THE PUBLIC AND TO GOVERNMENT ABOUT THEIR RESPECTIVE RESPONSIBILITIES WITH RESPECT TO DENTAL HEALTH.

Rationale: The Association recognizes that the dental profession has special responsibilities with respect to the nation's oral health. These special responsibilities relate at a minimum to the recognition of problems, the devising of appropriate solutions and a willingness to play a role in implementing those solutions.

The record of the profession is sound. It is now imperative that society's leaders support the dental profession on such matters as fluoridation, prevention and special attention to the needs of children. If they had done so earlier, the present oral health status of the country would be even better than it is. *Most importantly, individuals, government and society in general must recognize that they have an essential responsibility in obtaining and maintaining optimal oral health. In the field of prevention of dental disease, responsibility of government is key for the successful expansion of fluoridated water supplies.* The Board believes it essential to speak forcefully about the respective responsibilities the individual patient, all levels of government and society must assume if rapid progress is to be made.

8. RECOGNITION THAT THE TRADITIONAL FORM OF PRIVATE PRACTICE WILL REMAIN THE MAJOR SOURCE OF DENTAL CARE COUPLED WITH AN UNDERSTANDING THAT OTHER SOURCES OF CARE EXIST AND SHOULD RECEIVE OBJECTIVE ATTENTION.

Rationale: In the final analysis, the people of the United States decide the type of dental care delivery system that will exist in this nation. Throughout the country's history, Americans have demonstrated their preference for a dentist in private practice. There is every reason to believe that this pattern of choice will continue in the future. The Board intends to take every opportunity to continue to point out the advantages the patient receives from this form of dental care delivery.

Positive change can occur within the system in a number of ways. Proposals for sound change can come from any number of sources. The Association already maintains an active program of monitoring proposed or actual changes in dental care delivery. That program is directed toward objective examination. Its proper end is to inform the public and the profession on both advantages and disadvantages. In continuing such monitoring, the Association intends to maintain its posture of even-handedness and to provide genuine evidence of how—from the patient's point of view—different practice configurations serve dental health needs. The Board is confident that the traditional form of practice can only be strengthened by candid and fair analysis. *Attention to other sources of dental care does not imply Association endorsement or support for those alternate delivery systems but does provide objective data through effective evaluation so that all systems of delivering care can be strengthened for the benefit of the patient.*

PART III: THE POOR AND WORKING POOR

Intent: This section of the report discusses the poor and working poor who are: (1) under the age of 65; (2) not institutionalized or handicapped and (3) living in metropolitan areas and other nonrural areas. (These exclusions are designed to help diminish the degree of overlapping in the full report since these are included in other sections of the report.)

About 33 million Americans, approximately 15% of the total population, are included in the group discussed in this section of the report.

The primary barrier to access to dental care for this segment of the population is lack of funds to pay for care.

Description: The poor are considered to be those families and individuals with incomes that fall within the federal government's concept of poverty.[1] The working poor are those who have incomes up to 50% above the poverty level.[2]

Depending upon family size and location, the poverty line in 1977 for nonfarm areas ranged from an income of $3,075 a year for a single person to $10,216 a year for families of at least seven members. The poverty line for a nonfarm family of four in 1977 was $6,191. Currently (1979) it is $6,660.

The average poor family in 1977 was one with four persons and an income of $3,438. This income is 45% less than the poverty threshold and not quite 20% of the average income of all families in the United States, which was $18,264 in 1977.

The profile of the poor contains disproportionate concentrations of minorities; children under the age of 18; the least educated and least skilled; the most frequently unemployed; families headed by women, and residents of inner cities.[3]

Though there are twice as many poor whites as poor blacks, fewer than 10% of the white population is poor while nearly 33% of the black population is in the poverty category (Figures One and Two[1, 2]).

Sixty percent of the poor live in metropolitan areas and 37% live in central cities of metropolitan areas.

FIGURE ONE

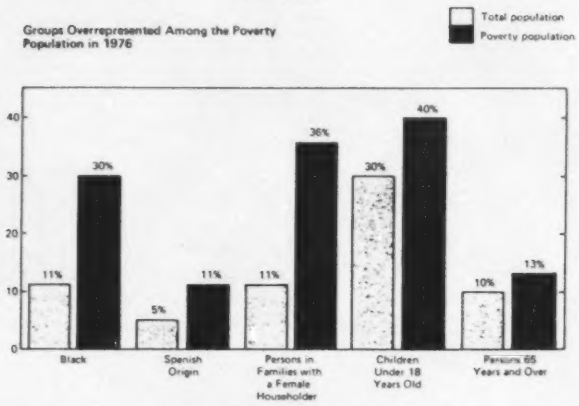
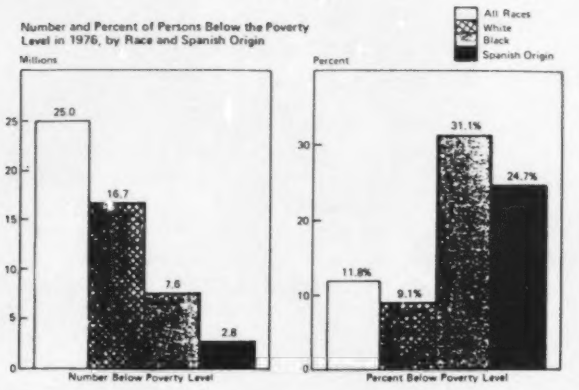


FIGURE TWO



Regionally, the number of poor and working poor is highest in the South and lowest in the West.

Appendix II presents a statistical overview of the poor and working poor being considered in this section of the report.

Appendix III shows the number of poor and working poor by age, race and residence, according to level of income.

Appendix III also presents the percentage of the total population who are poor or working poor by age, race and residence.

Finally, the poor and working poor are heavily concentrated in areas designated by the federal government as "poverty areas." These are urban census tracts and nonurban townships or districts where at least 20% of the residents have incomes at or below poverty level. In the total areas so designated, there are 40 million residents of whom 25.6% have incomes at or below the poverty level. Of the 20 largest cities of the nation, the following have the largest percentage of total population with incomes at or below poverty income levels: Newark, 37%; St. Louis, 25%; Philadelphia, 23%; Chicago, 22%; Boston, 22%; and Detroit, 20%.

It is important to recognize that since many of these problems affect minorities, the Association will intensify its efforts to work with groups such as the National Dental Association in trying to improve access.

Although the so-called War on Poverty did, in fact, mitigate some of the worst problems of poverty, it also had the effect of making the poor dependent on governmental programs. Virtually all of the poor are clients of the welfare system, depending on governmental cash benefits and an array of noncash services.

Social welfare expenditures, including programs under Social Security, are two-thirds of the federal monies spent and now amount to $350 billion annually. Over $50 billion is spent for public aid by the federal, state and local governments. The major programs through which cash or service benefits are channeled are: aid to families with dependent children; supplemental security income; general assistance for the needy who do not qualify for either of the two preceding programs; food stamps; and Medicaid. Cash benefits are about 77% of aid to the poor and services of a noncash nature constitute about 23% of the total.

Dental Health of the Poor and Working Poor: By all available measures, utilization of dental services by the poor and working poor is far below that of the middle and upper income groups.

Figures Three and Four present some summary statistics bearing on these facts.

Poor dental health begins in childhood. Although the availability of children's dental programs has increased utilization by the low income school-age population (6 to 16 years), their use of services has never approached that of more affluent children. In families earning above the median income, 75% of school-age children have dental visits; among the poor and working poor, the percentage is below 50%. In the more affluent group, school-age children average nearly three annual visits per capita whereas the poor and working poor in the same age group average less than 1.5 annual visits per capita. Poor children average 3.4 unfilled carious teeth; children in the more affluent groups average 0.7.[4]

Among adults aged 25 to 44 years, about 40% of the poor and working poor have dental visits in one year, compared with 63% in families earning more than $15,000. In the latter group, the percentage visiting a dentist remains over 60% in the 45 to 64 year age group; for the poor and working poor, the percentage drops to 30% and lower for ages 45 to 64. It is lower still for the elderly. Low income adults between the ages of 45 and 64 are almost three times as likely to be edentulous as are adults of the same age who earn more than $15,000. An estimated 43% of the poor over age 45 are edentulous, compared with 15% for persons in the same age group earning more than $20,000.[5]

Impact of Medicare and Medicaid on Health Utilization: One of the most striking changes to occur since the mid-1960's is the increased use of *medical* services by low-income

FIGURE THREE*

Percentage of Population with One or More Dental Visits in 1976, by Family Income and Age

Age	Annual Family Income: Under $3,000	$3,000–4,999	$5,000–6,999	$15,000 and over	All incomes
All ages	33.6%	33.5%	36.0%	61.9%	48.7%
Under 6 years	13.2	15.8	14.0	30.0	21.2
6–16	45.2	48.7	47.1	75.3	63.1
17–24	58.0	48.8	45.0	63.5	54.9
25–44	38.0	37.5	39.1	62.7	53.0
45–64	24.3	28.4	31.8	60.1	46.5
65 yrs. and over	16.0	23.2	29.4	44.3	29.8

FIGURE FOUR*

Average Number of Dental Visits per Person in 1976, by Family Income and Age

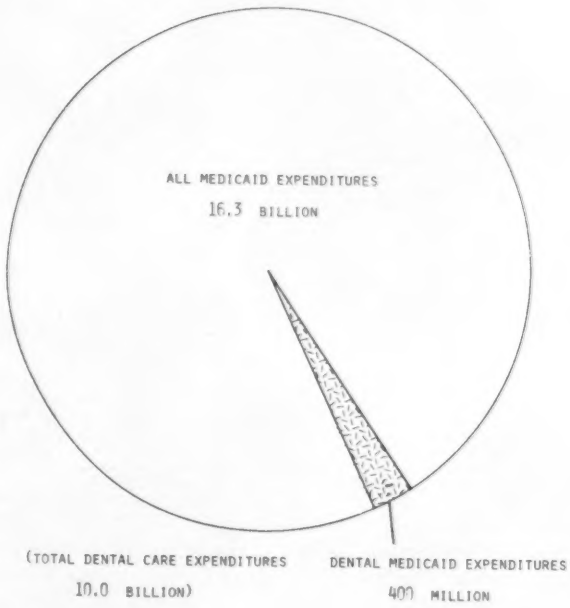
Age	Annual Family Income: Under $3,000	$3,000–4,999	$5,000–6,999	$15,000 and over	All incomes
All ages	1.0	1.1	1.3	2.1	1.6
Under 6 years	0.2	0.2	0.6	0.7	0.5
6–16	1.3	1.3	1.0	2.7	1.9
17–24	1.8	1.7	1.3	2.2	1.8
25–44	1.0	1.1	1.4	2.1	1.7
45–64	0.8	1.0	1.4	2.2	1.8
65 yrs. and over	0.5	0.9	1.4	2.0	1.2

people. During this period, a major reversal occurred in the pattern of abnormally low use of medical services—not dental—by the poor. For the first time, the poor began to visit physicians as frequently as did the nonpoor. In 1964, the nonpoor saw physicians about 20% more frequently than did the poor. By 1975, the poor overtook those with higher incomes and were seeing physicians 18% more frequently than were the nonpoor. The hospitalization rate of the poor increased by 40% during this period, far surpassing that of other income classes.[4] To a far lesser extent, the poor have also made greater use of dental services, as a result of the inclusion of dental benefits in the Medicaid program of 35 states.

Dental Expenditures in the Medicaid Program: Payment for dental services under Medicaid amounted to $400 million in 1977, or 2.5% of $16.3 billion spent for all Medicaid services.[6] Medicaid dental expenditures are about 4% of the $10 billion spent for all dental care in the United States. Per capita annual dental expenditures in the nation for the total population are $45.41, of which $2.27 are public funds. Expenditures for dental care average $30.29 per child, $54.29 per adult under 64 years and $43.24 per elderly person (Figures Five and Six[6, 7]).

FIGURE FIVE

MEDICAID EXPENDITURES, 1977



The $400 million in Medicaid dental expenditures is distributed as follows: $190 million for children under 21, or $19 per child in the Medicaid program; $131 million for adults receiving AFDC or other assistance, or $27 per adult Medicaid recipient; $32 million for the elderly, or about $8.50 per elderly Medicaid recipient; and $48 million for the blind and disabled, or $15 per Medicaid recipient in that category.

Thirty-five of 52 states and territories provide some form of dental coverage for Medicaid beneficiaries, and 22 states extend coverage to the medically needy. Due to extreme variations in coverage among the state programs, nearly half of Medicaid dental funds are spent in five states and three-fourths of Medicaid dental benefits are paid to recipients in 12 states.[7] But only three of the latter 12 states spend more than $30 per Medicaid recipient for dental care. The 12 states in which 75% of Medicaid dental funds are spent provide an average of $25 per Medicaid recipient in dental benefits. (See Figure Seven.[6, 7])

Appendix I shows Medicaid expenditures for dental benefits per recipient, by state, and also presents an estimate of additional funds needed in each state to

*National Center for Health Statistics, U.S. Department of Health, Education, and Welfare; unpublished data from the Health Interview Survey, 1976.

FIGURE SIX

PER CAPITA DENTAL EXPENDITURE, 1977

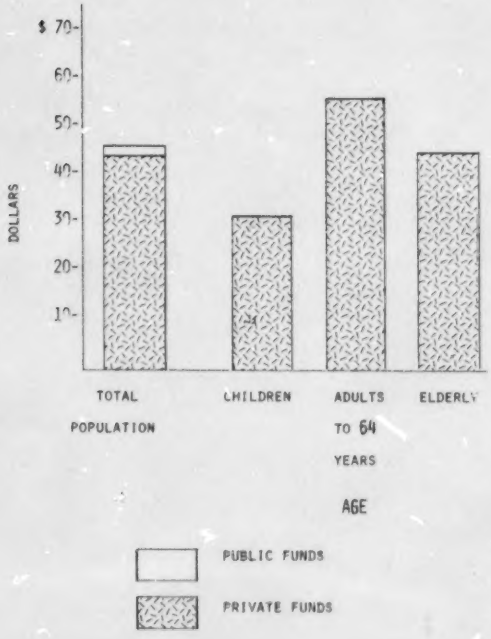


FIGURE SEVEN

TOTAL MEDICAID POPULATION BY SIZE OF STATE PROGRAMS

FY 1974

TEN LARGEST STATES

(67.8%)

20 LARGEST STATES

(83.4%)

provide reasonably comprehensive dental benefits to all Medicaid recipients. Medicaid dental expenditures per recipient are highest in some of the less populous states: Hawaii ($58), Nevada ($48), Wisconsin ($42), Iowa ($40), North Dakota ($38), Washington ($38) and Arkansas ($37). In Hawaii dental benefits are 9.4% of all Medicaid benefits, compared to the national average of 2.5%.

The estimate in Appendix I assumes that an annual expenditure of $100 per Medicaid recipient is adequate to provide reasonably comprehensive care to the group. On this basis, an additional expenditure of $1.8 billion in the first year would be required to fund adequately the dental portion of the Medicaid program. This would amount to about 11% of current Medicaid expenditures for health services.

Association Efforts with Respect to Poor and Working Poor: The general thrust of Association activity with respect to this segment of the population has been positive and is of a long duration. Some policies date back decades. More recent ones include support for the use of public funds "for those unable financially to pay for health services themselves";[8] a directive to "require the inclusion of dental care benefits for all persons eligible under Medicaid";[9] support for the enactment of the Early and Periodic Screening, Diagnosis and Treatment section of Medicaid; and, most recently, efforts to assure that the CHAP proposal of the Carter Administration would not exclude the dental care needs of the beneficiaries.

Association efforts have not been wholly unsuccessful. Dental benefits are, in effect, mandated for poor children if not for adults. To the degree, however, that states would include dental care for the adult poor, the federal government is committed to contributing matching funds. One failure at this point, then, has been the inability of the profession to persuade state governments to take such action.

With respect to the poor and the working poor, then, the Board intends to take the following actions:

9. PRESS FOR MORE EFFICIENT ADMINISTRATION OF AND MORE EQUITABLE REIMBURSEMENT UNDER MEDICAID AND SIMILAR PROGRAMS.

Rationale: It is the Board's belief that tens of thousands of American dentists would now be participating in the Medicaid program had they not been forced out by chaotic maladministration, payment levels set so low as to all but guarantee insolvency and interminable waits for reimbursement. None of that is neces-

sary. In California, since the Medicaid program has been administered by California Dental Service, the number of practitioners who participate has increased from about 30% to 90% of the total number of dentists. In all candor, California Dental Service has achieved this through simply efficient administration and prompt reimbursement of the payments owed dentists.

Association agencies will work even more intensively in the future to achieve similar efficient administration of programs throughout the country.

10. INTENSIFY EFFORTS AT THE FEDERAL LEVEL TO MANDATE BASIC DENTAL BENEFITS FOR ALL MEDICAID RECIPIENTS.

Rationale: While the so-called War on Poverty effectively mitigated many of the worst problems of poverty, it also had the effect of making the poor almost entirely dependent on an array of government programs offering both cash benefits and noncash services. With regard to medical services, virtually all of the nation's poor have become reliant on the Medicaid program.

Clearly, Medicaid has had a dramatic impact on increasing access to and utilization of *medical* services among low-income persons. However, the program virtually ignores the oral health needs of the poor. In view of the Association's strong support of appropriate amendments to the Medicaid law, the Board will direct appropriate Association agencies to intensify efforts at the federal level to (1) obtain mandated dental benefits for all Medicaid recipients; (2) assure the inclusion of dental care benefits in amendments to any health care program aiding the poor and working poor; and (3) maintain optional matching funds for dental care under Medicaid.

11. EXPLORE THE FUNDING OF A PILOT PROGRAM TO OBTAIN BROADER MEDICAID DENTAL CARE BENEFITS AT THE STATE LEVEL.

Rationale: Although each state Medicaid program has its costs partially underwritten by the federal government, it administers its Medicaid program under broad federal guidelines with considerable flexibility in establishing benefits, payment structures and eligibility requirements. Federal law requires each state participating in Medicaid to provide basic health services for the categorically indigent and then allows each state the choice of offering basic health services for persons determined to be medically indigent (the working poor). Among the mandated basic health benefits are comprehensive dental services for children under the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program. As previously mentioned, few states have complied with the mandate to implement EPSDT, mainly for financial reasons.

In order to improve the opportunity of the poor to receive regular dental care, the Association must focus its attention not solely upon obtaining a federal mandate for basic dental services under Medicaid but must also seek action by state legislatures to (1) upgrade existing adult dental benefits where they exist and (2) provide for adequate dental benefits where they do not exist. This should be done in cooperation with all interests within a state who will help.

When the 1977 House of Delegates directed the Association to seek federal legislation to mandate basic dental benefits under Medicaid, it also directed appropriate Association agencies to prepare materials to assist constituent societies in improving Medicaid dental programs through state action. The Council on Dental Care Programs, in response, prepared "Action Plans for Constituent Dental Societies," a guidebook that sketches ways in which constituents can work to improve Medicaid dental benefits through their state agencies and legislatures. In addition, the Council held in 1978 a special conference on Medicaid dental benefits, the proceedings of which are available to societies.

An even more intensive effort is now needed. Severe shortcomings in many state Medicaid dental benefits still remain nearly 15 years after the inception of the program. The Board believes it is time for the Association and its constituent societies to initiate a more aggressive state action plan to improve Medicaid dental benefits in states where such benefits are deficient. This effort might best begin with a series of state-level demonstration programs. Without considerably greater financial commitment to Medicaid dental benefits at the state level, no significant inroads can be made in improving the opportunity of the poor to receive regular dental care.

12. EXPLORE THE USE OF ELEMENTARY AND SECONDARY SCHOOLS IN PROVIDING PATIENT EDUCATION, REFERRAL AND ORAL PROPHYLAXIS DENTAL SERVICES TO CHILDREN.

Rationale: It is estimated that there are some 12 million school-aged children from poor and working poor families who are not receiving sufficient dental care. It is critical to reach children, especially children of the poor and working poor, in order to provide meaningful preventive services that can reverse a pattern of poor oral health which these patients exhibit in young adulthood. The Association believes prevention and adequate patient referral are the most essential keys to improving the oral health status of the country over the long term. Logical settings for reaching such children are the elementary and secondary schools which they attend throughout the year.

Scattered throughout the nation there are a few examples of such use of the school setting. There is every indication that these programs work well. The existing programs make use of both dentists and dental hygienists and provide an excellent outreach opportunity for providing these valued preventive services to a large segment of the population. The Board intends to initiate fuller exploration of this type of outreach program *consistent with Association policy and state law.*

References

1 and 2. Bureau of the Census, *Current Population Reports*, Series P–60, No. 116, July 1978.

3. Bureau of the Census, *Current Population Reports*, Series P–60, No. 119, March 1979.

4. Davis and Schoen, "Health and the War on Poverty: A 10 Year Appraisal," The Brookings Institution, pp. 40–43, 1978.

5. National Center for Health Statistics, *Vital and Health Statistics*, Series 10, Number 89, June 1974.

6 and 7. *Data on the Medicaid Program, Fiscal 1976*, Health Care Financing Administration (HEW), compiled for the Commerce Committee of the U.S. House of Representatives, pp. 42–45, 1977.

8. *Transactions,1977*, American Dental Association, p. 918.

9. *Transactions,1977*, American Dental Association, p. 912.

APPENDIX I: ESTIMATE OF ADDITIONAL FUNDS NEEDED TO PROVIDE COMPREHENSIVE DENTAL BENEFITS IN MEDICAID PROGRAM*

State	Number of Medicaid Recipients**	Dental Benefits per Recipient**	Estimated Additional Funds Needed for Comprehensive Care*** (in $ millions)
Alabama	361,000	$ 8.31	$33
Alaska	8,000	0	1
Arizona****	—	—	12
Arkansas	136,000	36.76	9
California	3,713,000	17.24	307
Colorado	144,000	6.94	13
Connecticut	188,000	21.28	15
Delaware	48,000	0	5
District of Columbia	141,000	7.09	13
Florida	351,000	8.55	32
Georgia	454,000	22.03	35
Hawaii	86,000	58.14	4
Idaho	33,000	30.30	2
Illinois	1,140,000	23.68	87
Indiana	223,000	17.94	16
Iowa	126,000	39.68	7
Kansas	143,000	34.97	9
Kentucky	339,000	14.75	29
Louisiana	290,000	0	29
Maine	105,000	19.05	9
Maryland	405,000	24.69	31
Massachusetts	923,000	23.84	70
Michigan	904,000	28.76	64
Minnesota	241,000	33.20	16
Mississippi	275,000	10.91	25
Missouri	346,000	11.56	31
Montana	39,000	25.64	3
Nebraska	69,000	28.99	5
Nevada	21,000	47.62	1
New Hampshire	45,000	22.22	4
New Jersey	572,000	31.47	39
New Mexico	72,000	13.89	6
New York	2,930,000	18.43	239
North Carolina	233,000	34.33	15
North Dakota	26,000	38.46	2
Ohio	706,000	21.25	56
Oklahoma	232,000	8.62	21
Oregon	138,000	21.74	11
Pennsylvania	1,531,000	11.10	136
Puerto Rico	1,809,000	.55	180
Rhode Island	111,000	18.02	9
South Carolina	183,000	16.39	15
South Dakota	29,000	0	2
Tennessee	255,000	11.76	23
Texas	686,000	2.92	67
Utah	66,000	30.30	5
Vermont	47,000	21.28	5
Virginia	293,000	13.65	25
Washington	286,000	38.46	18
West Virginia	128,000	7.81	12
Wisconsin	333,000	42.04	19
Wyoming	28,000	0	2
United States	21,991,000	$17.60	$1,827

*Also note Figure Seven on page 14.

**1976 data.

***Assumes dental expenditure of $100 per beneficiary. Assumes no change in eligibility with regard to medically indigent.

****No Medicaid program.

APPENDIX II

THE POOR AND WORKING POOR: A STATISTICAL SUMMARY

Number of poor (the poverty population)	25 million
Number of poor, subtracting the aged, handicapped and those in remote areas	17 million
Number of working poor (from poverty line to 50% above poverty income)	23 million
Number of working poor, subtracting the aged, handicapped and those in remote areas	16 million
Median non-farm family income of the poor, 1977	$3,438
Median non-farm family income of working poor, 1977	$7,655
Median family size, poor and working poor	4 persons

In 1977, the average income of a non-farm poverty family of four was 45% below the poverty threshold and less than one-fifth the average income of all families in the United States.

Median income of black families is 57% of the median for white families.

Groups Overrepresented in Poverty Population

	Percent in Poverty Population	Percent in U.S. Population
Black persons	30%	11%
Persons of Spanish origin	11	5
Families headed by women	36	11
Children under 18 in families headed by women, no husband present	55	5

APPENDIX III

NUMBER OF POOR AND WORKING POOR, 1977

	Number in Millions		
	Below Poverty Level	Poverty Line to 25% Above	25% to 50% Above Poverty Level
All persons	24.7	11.6	12.6
White	16.4	8.4	10.0
Black	7.7	2.5	1.9
Age: Under 21	12.2	4.1	5.4
21-44	5.8	3.1	2.3
45-64	3.6	2.1	3.0
65 and over	3.2	2.3	1.9
In metropolitan areas	14.9	6.1	8.6
Central cities	9.2	3.0	4.6
Outside central cities	5.7	3.1	4.0
Non-metropolitan, non-farm areas	8.5	5.3	3.8
Region: Northeast	5.0	2.3	3.0
North Central	5.6	2.5	2.9
South	10.2	4.7	4.5
West	3.9	2.1	2.2

POOR AND WORKING POOR AS PERCENTAGE OF POPULATION, 1977

	Percentage of Population		
	Below Poverty Level	Poverty Line to 25% Above	25% to 50% Above Poverty Level
All Persons	11.6%	5.4%	5.9%
White	8.9	4.5	5.4
Black	31.3	10.1	7.7
Age: Under 21	15.4	5.2	6.8
21-44	8.5	4.5	3.4
45-64	8.3	4.8	6.9
65 and over	14.3	10.2	8.4
In metropolitan areas	10.4	4.3	6.0
Central cities	15.4	5.1	7.0
Outside central cities	6.8	3.8	4.4
Non-metropolitan, non-farm areas	13.4	8.4	7.5
Region: Northeast	10.2	4.7	6.1
North Central	9.8	4.4	5.1
South	14.8	6.8	6.5
West	10.1	5.4	5.6

PART IV: THE ELDERLY

Intent: This section is concerned with the elderly, those Americans who are 65 years of age or older.

It attempts to place in perspective the *total* dental health needs of the elderly. Within the context of total dental health needs it discusses the way in which denture services are now sought and received by the elderly.

The primary barrier to access to dental care for this segment of the population is their age itself with its implications for reduced earning power, greater health expenses and physical dependence.

Description:[1] In 1976, there were 22.9 million elderly persons in the United States, forming 10.7% of the total population.

Of this total, 62% are aged 65–74; 29% are 75–84; and the remaining 9% are 85 years of age or older.

Nearly 60% of the elderly are female and over 90% are white. At age 65, remaining life expectancy is 15+ years (See Figures One, Two[2] and Three[3]).

More than half the elderly live in an urban setting. The median income of families headed by elderly persons was $8,057 in 1975 while the median income per person in 1975 for the elderly was $3,655.

In 1959, 35% of the elderly were classified as poor while in 1974, 16% were in this classification. Excluding Social Security payments, 60% of all families headed by an elderly person would have an income below the poverty level.[4] The percentage is much higher for certain segments of the elderly, including individuals not in families, women and blacks.

The educational level of the elderly is less than that of the general population. The median number of school years completed is nine years and about one-third have

completed high school. (The educational level is rising and will continue to do so in the future.)

Over 3.5 million of the elderly have some type of mobility limitation because of a chronic condition. Some 30% of these have severe disabilities that keep them confined to their homes.

In 1974, about 927,000 elderly persons were in nursing homes. Of these, more than 80% were at least 75 years of age (Figure Four[5]).

FIGURE ONE

THE ELDERLY AS A PERCENTAGE OF THE POPULATION, 1976

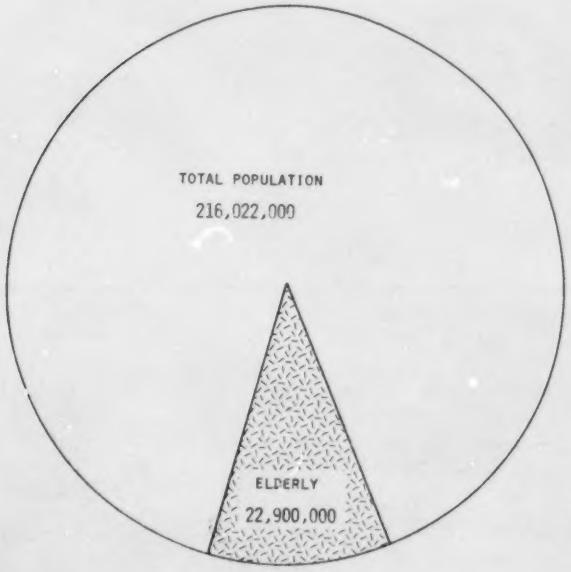


FIGURE TWO

PERCENT DISTRIBUTION OF THE ELDERLY, 1976

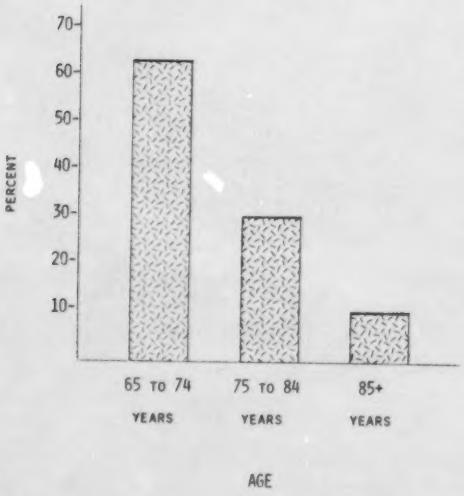


FIGURE THREE

NUMBER OF EDENTULOUS PERSONS PER 100 POPULATION FOR PERSONS AGED 45 YEARS AND OVER, BY AGE, RACE, AND SEX: UNITED STATES, 1971

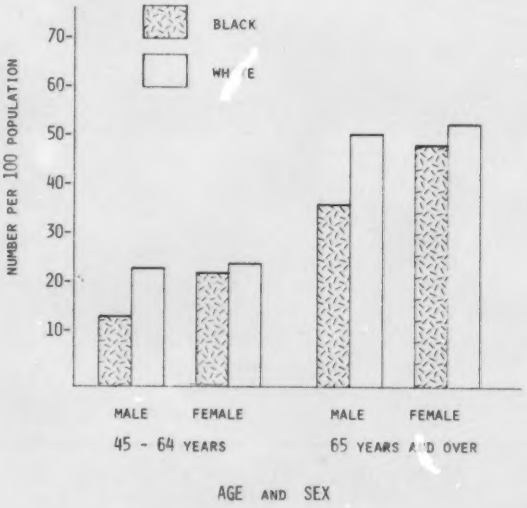
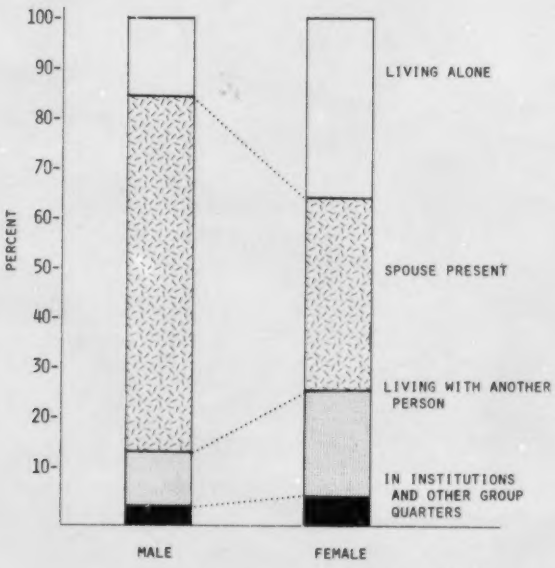


FIGURE FOUR

PERCENT DISTRIBUTION OF THE MALE AND FEMALE POPULATION 65 YEARS OLD AND OVER BY LIVING ARRANGEMENTS: 1975



The noninstitutionalized elderly average 6.5 physician visits a year, with 80% visiting a physician at least once a year. In 1975, Medicare supplementary medical insurance paid about 54% of the cost of visits to physicians by the elderly.

Appendix I shows the variety of personal health care expenditures for those 65 years of age or older as of fiscal 1975.[6]

Utilization of Dental Services by the Elderly:[7] Between 1971 and 1975, the total number of dental visits a year by the elderly increased more than 20%. In the same period of time, the percentage of the elderly who visited a dentist increased from 26% to 30%. In 1975 then some 70% of the elderly did not make a dental visit. In fact, 62% had not seen a dentist in over two years and 47% had not seen a dentist in the previous five years. The percentage of elderly with no dental visit in five years is twice that of the group aged 45 to 64 years and nearly four times higher than the average for the total population. Appendix II shows summary statistics on timing of dental visits for all categories of the population, including the elderly[8] (See Figure Five[2]).

In 1975, as well, some 40% of those *more than 60 years of age* wore at least one complete denture. An additional 16% report having all their natural teeth and another 38% report having partial dentures or some missing teeth but not wearing full dentures.

In January 1978, the Association commissioned the Opinion Research Corporation to conduct a national survey concerning dental care and self-perceived dental status. While the study was so structured that reports on the "elderly" *include those 60 years of age and above*, the responses illuminate the attitudes of the population being discussed in this section of the report.

In a paper delivered in March, 1979 before the International Association for Dental Research, Dr. Helen C. Gift of the Association staff presented some of these findings from the study (Figure Six[9]). Excerpts are attached to this report as Appendix III.

Changing Status of the Elderly: Though a number of persons who are elderly fall, because of other characteristics, into a category where access is an admitted problem, the elderly themselves have not before been the subject of specific attention with respect to access by the Association.

This is not surprising since, until relatively recently, the elderly were not even considered to be an identifiable group with salient characteristics.

There have been changes in the status of the elderly, however, in the past few decades. The significance, in dental health terms, is notable. Of these changes, four deserve specific mention.

The first is the diminishing purchasing power, over a long period, of the Social Security pension. When established nearly fifty years ago, Social Security had a goal of providing an income "floor" during retirement in combination with private arrangements. Increasingly severe and frequent bouts with inflation have eroded that objective. The extraordinary increase in health care costs—and range of available services—has highlighted the area of health.

A second change is the weakening of the family structure. We have gone, as a society, from a time when entire families would commonly live in the same commu-

FIGURE FIVE

PERCENT DISTRIBUTION OF ELDERLY BY TIME INTERVAL SINCE LAST DENTAL VISIT ACCORDING TO SEX AND AGE: UNITED STATES, 1977

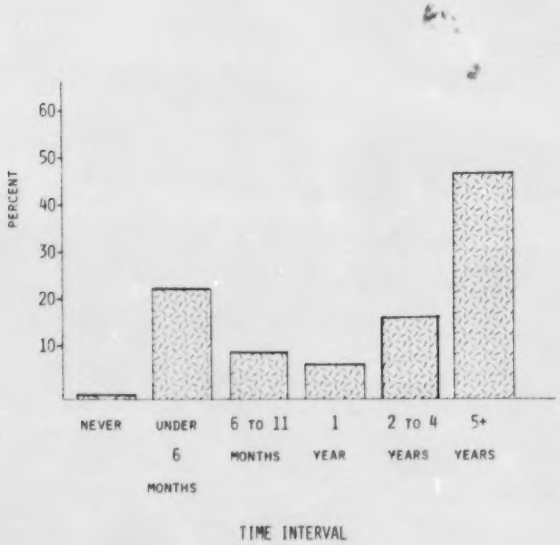
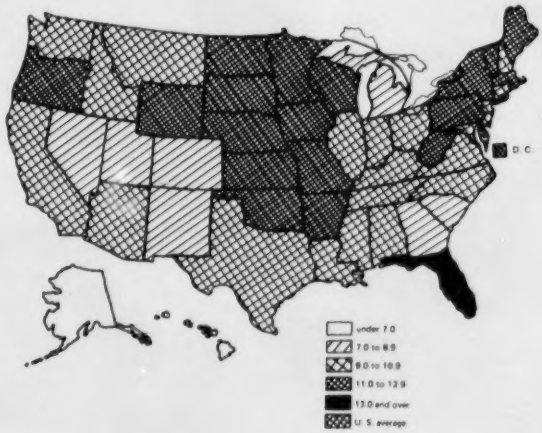


FIGURE SIX

PERCENT 65 YEARS AND OVER OF THE TOTAL POPULATION, UNITED STATES, 1975



nity to a time when families are commonly scattered across the nation. Many elderly—whether in nursing homes or in private residences—are physically isolated from the sons and daughters who once lived supportively near. In such isolation, the elderly must cope with the exigencies of daily life on their own, whether that day's chore is grocery shopping or a dental visit.

Thirdly, the proportion of elderly in the society has increased. It is now nearly 11%.

Finally, remarkable advances in medical art and science prolong life for many but, in doing so, give rise to some physical, economic and psychological problems that we do not fully understand, much less know how to solve.

Facts such as these have tended to transform the elderly into an identifiable segment of society with particular problems, common goals and sufficient power to be a political force.

Parallel to these changes came the enactment of Medicare which has had effects of its own. It first of all identified health care costs as a special item, causing public concentration on health care organization and costs that may not have otherwise occurred. Secondly, Medicare purported to include all the health care services that the elderly would need. Thirdly, it was designed to pay all or a large share of the cost of those services.

As with Social Security pensions, Medicare was enacted as an earned right, not a matter of charity.

In fact, of course, Medicare is not everything it is sometimes thought to be. It does not cover all necessary health services and, consequently, does not pay the cost attendant upon receiving them. Dentistry stands out with special clarity as a service excluded from Medicare. For a long period of time, the profession explicitly supported that by opposing amendments to Medicare that would add dental benefits.

The most recent expenditure estimates are, in this respect, of interest. In fiscal 1977, per capita *health* expenditures for the elderly were $1,745, of which $1,169 or about 67% were public expenditures; in fiscal 1977, the elderly's per capita *dental* expenditures were $43, of which $41 or 96% were out-of-pocket.

Dentistry and The Elderly: Throughout this period of change in the status of the elderly one contact between organized dentistry and the organized elderly was the illegal provision of dentures by the nondentist. This gave the relationship a narrow and negative tone. Dentistry seemed to be concerned only with one of the dental services the elderly require—over 40% are not edentulous—and, further, seemed primarily concerned with preventing that service from being performed except on dentistry's unilateral terms.

This is in stark contrast to the relationship dentistry has tried to establish with other groups. With them, dentists showed awareness of the fact that there were barriers to access and that they were trying to do something positive to eliminate them.

Over the past few years, the profession has sharply intensified its efforts with respect to denturism. Allowing for outstanding exceptions, these efforts have often been such as to reenforce the notion that dentists were primarily interested in preventing a service from being provided except on dentistry's unilateral terms. The postelection research in Oregon tends to confirm this.[10]

Denture Service: Although there have been proposed changes in laws that govern the delivery of denture care, the dental profession has been able to demonstrate that such changes would endanger the public health and that the profession was meeting the denture care needs of the public.

The provision of total denture treatment requires an understanding of many biologic, anatomic and physiologic principles that must be assessed for each individual patient. This understanding is fundamental to individuals who are properly trained in these disciplines and who can assume responsibility for the total health of the patient. The dentist is the only person who has the necessary training to assume this responsibility. The dental community has assumed its responsibility of providing denture care to those segments of the population with limited financial resources. Many state and local dental societies have established programs that provide low cost denture care, generally within the private practice setting. In many states, these programs have responded to the need of the elderly and indigent to obtain quality denture care from licensed dentists at fees commensurate with the patient's financial resources. The more extensive availability of such programs would accomplish much in meeting the needs of those individuals who are unable to enter the current system of dental care delivery. The American Dental Association encourages the implementation or the expansion of those programs.

Present Efforts: With specific reference to combatting illegal dentistry, the Association has now brought together an array of programs. These include:

—*staff assistance:* on-site assistance by the Association to constituent societies in such matters as legislation, public relations, legal affairs and laboratory relations;

—*legislative training aids:* a trigger film, audio tapes and a manual to supplement a legislative package of materials on oral health care for the edentulous;

—*public health forums:* meetings with key representatives of the public designed to allow the public to express their views about the dental delivery system;

—*press materials:* a kit of materials on denture care for the news media;

—*senior citizen alliances:* a manual on how to contact and work with senior citizen groups on matters of oral health care for the elderly;

—*access techniques:* a manual on how a state society can set up a program to increase access to denture care;

—*socioeconomic and attitudinal studies:* two studies emphasizing a demographic profile of the elderly and an assessment of the real need for dental care among the elderly.

On the whole, these programs have been well-financed relative to Association resources. Other programs are continually being suggested, including expanded use of spokesmen in public settings to discuss the dangers of illegal dentistry and more active approaches to newspapers, magazines and electronic media. None of them, as techniques, can be faulted. Viewed separately, they may justify continued emphasis, but emphasis within the context of positive access to the full dental needs of a group of people. This would also include the publications and programs that have been developed and that are listed in Appendix IV to this section. Other Association activities that touch this area, such as some aspects of prepayment and some legislative goals, also need to be placed within this context.

With respect to the elderly, then, the Board intends to take the following actions:

13. EMPHASIZE COMPREHENSIVE DENTAL SERVICES IN ADDRESSING THE NEED OF THE ELDERLY.

Rationale: More than 40% of today's elderly population is not edentulous. All available information indicates that this percentage will increase among the elderly of the future. This is a genuine victory for dental health. Association activities need, therefore, to be directed toward the diverse dental care needs of the elderly. Our present concentration on denture care will be better balanced with the addition of more activities promoting comprehensive dental services for the elderly. To be effective, such programs must take into account the financial status of most elderly people as well as mobility limitations as they exist.

The Association will continue its opposition to sublevel dental care, but its primary emphasis will be placed on making denture care available at a lower cost to the patient.

Important to the success of activities to increase the availability of comprehensive dental services are the participation and support of organizations representing the elderly. These large, well-financed, active organizations are becoming increasingly influential at all levels of government. Such groups include the American Association of Retired Persons, representing 12 million members, and the Senior Citizens Council, with 6 million members. The assistance and counsel of these organizations in the development and promotion of comprehensive dental care programs for the elderly would be important to the success of these efforts.

14. INTENSIFY EFFORTS TO AMEND MEDICARE TO INCLUDE DENTAL BENEFITS.

Rationale: No single action could do more to expand the opportunity for all elderly to obtain needed dental care than would amendment of Medicare to include dental benefits. As in previous Congresses, the 96th Congress has several bills that would include dental benefits under Part B of Medicare. The Association has policy supporting such amendments though neither Congress as a whole nor the Executive Branch has yet demonstrated an interest in joining the dental profession in helping America's senior citizens in this way. One method of elevating this item in the list of Congressional and Administrative priorities would be to enlist the support of senior citizen organizations for such an amendment. An intensified campaign soliciting such support will be waged during this Congress. While the ultimate achievement will be to pass dental benefits into law, the cooperative waging of a legislative effort with senior citizen organizational support will, of itself, be beneficial to the profession.

15. SEEK WAYS TO EXTEND PRIVATE GROUP DENTAL PREPAYMENT BENEFITS TO THE ELDERLY.

Rationale: There is a trend now for group dental prepayment benefits to be carried into retirement. That trend has been monitored by the Association and, in related efforts, there have been investigations of the feasibility of a *private* sector group prepayment program just for the elderly. Appropriate agencies will review the present status of these linked efforts and intensify action as feasible to stimulate extension and expansion of dental prepayment benefits in these two ways.

16. DEVELOP MINIMAL CRITERIA THAT STATE DENTAL SOCIETIES MUST TAKE TO BE ELIGIBLE FOR ASSOCIATION ASSISTANCE TO PROVIDE ACCESS PROGRAMS FOR DENTURE CARE.

Rationale: If the Association's funds and reputation are to be involved in a state-based campaign to improve access to denture care, the Association must play a meaningful role in planning and waging such a campaign. The implications of sublevel denture care in *any* state for the dental health of *all* Americans are obvious.

To address the issue of sublevel, illegal denture care, the Association must concentrate on efforts that will remove the fundamental problem, which is the unavailability of low-cost denture care in *all* areas. Explicit criteria, announced well in advance, will help constituent societies in shaping programs for which they may intend to seek Association assistance. Such criteria will contain the following elements:

—require identification and recruitment of dentists of sufficient number and geographic distribution to participate on a continuing basis in a reduced fee denture care program;

—provide at the Association's expense the resources and dental experts necessary to train den-

tists in denture service techniques that promise greater efficiency and lower cost to the patient;

—provide full Association participation in all communications to general and special audiences on the profession's position;

—solicit active cooperation from citizen groups, organizations of the elderly, state government and other groups considered by the Association to be essential to a successful program.

17. INVESTIGATE WAYS TO IMPROVE INCREASED OPPORTUNITY FOR DENTAL CARE FOR THE ELDERLY THROUGH A GREATER AVAILABILITY AND EFFECTIVE UTILIZATION OF DENTISTS AND DENTAL AUXILIARIES.

Rationale: In recent years the Association has explored and participated extensively in the general study of role, function and delegation of duties to auxiliaries under the state law defined supervision of a dentist. Current Association policy states:

> The Association believes that nothing should restrict the capacity of the profession to investigate and consider various methods of dental care delivery, including increased utilization of dental assistants and dental hygienists in traditional as well as extended roles; and that the dental practitioner must be involved in determining the appropriate implementation of results of such investigation.
>
> The dentist is responsible for patient services and in carrying out that responsibility makes decisions on the most effective utilization. Those provisions must be included in practice acts and provide assurance to the dentist that auxiliaries will have appropriate education and training and meet whatever additional criteria are needed to guarantee competence.

While other studies and organizations, as well as legislatures, may continue to recommend changing these basic patterns and relationships, the Board believes it is in the public's best interest to continue its own explorations. In such explorations, the Board will cooperate with the Association agencies, other national dental organizations interested in and concerned with the issue of greater availability and cost–effectiveness of dental services, and will emphasize specific studies to deal with providing the dental care needs of the elderly.

18. ESTABLISH A NATIONAL ORGANIZATION CONCERNED WITH THE DENTAL HEALTH OF THE ELDERLY.

Rationale: The Association now has, either directly or through cooperative effort, programs addressed to specific aspects of dental care and/or dental health problems of specific groups within the general population. Such programs include grant relationships such as those with the National Foundation of Dentistry for the Handicapped, the American Association of Dental Schools and the International Association for Dental Research.

No such program now exists with respect to the dental health of the elderly. Further, there is no national dental organization of size that has the dental health of the elderly as a specific interest; the American Society for Geriatric Dentistry is the only such group.

An organization representative of all health disciplines could play an important role as a clearinghouse agency to relate dental health needs to the general health and socioeconomic concerns of the elderly. It would further provide an access point for senior citizen organizations to address their health concerns. The existence of such an organization would have no direct effect on the Association's own policy stance nor would it supplant current Association efforts. In exploring this avenue, the Board would seek to work closely with the American Society for Geriatric Dentistry and determine whether that society could be the focal point of any new organization that might be developed.

References

1. *The Elderly: A Socioeconomic Profile*, Bureau of Economic Research and Statistics, American Dental Association, 1977 and Gift, Helen C. *Attitudes and Dental Health Status of the Elderly*, unpublished paper delivered March 30, 1979 at the International Association for Dental Research.

2. *The Elderly: A Socioeconomic Profile*, Bureau of Economic Research and Statistics, American Dental Association, 1977 and U.S. Department of Commerce, Bureau of the Census.

3. *Edentulous Persons, United States—1971*, data from the National Health Survey, Series 10, No. 89, HEW, 1974.

4. *The Economics of Aging*, the National Journal, p. 7, Dec. 1978.

5. Bureau of the Census, 1975.

6. *Age Differences In Health Care Spending, Fiscal Year 1975*, Social Security Administration, 1976.

7. *The Elderly: A Socioeconomic Profile*.

8. *Current Estimates from Health Interview Survey*, National Center for Health Statistics, Series 10–115, 1976.

9. *The Elderly: A Socioeconomic Profile*, Bureau of Economic Research and Statistics, American Dental Association, 1977 and Bureau of the Census, *Current Population Reports*, Series P–23, No. 59, Issued May 1976.

10. *Oregon Initiative: Results of Post-Election Research*, Bureau of Economic and Behavioral Research, American Dental Association, 1979.

APPENDIX I

Estimated amount, percent distribution, and per capita personal health care expenditures for persons 65 years and over, fiscal year 1975

Type of expenditure	Total	Source of funds			
		Private	Public		
			Total	Medicare	Other
		Amount (in millions)			
Total	$30,383	$10,466	$19,917	$12,749	$7,169
Hospital care	13,467	1,379	12,088	9,719	2,369
Physicians' services	4,862	1,987	2,875	2,628	247
Dentists' services	540	502	38	0	38
Other professional services	441	220	221	167	54
Drugs and drug sundries	2,629	2,285	344	0	344
Eyeglasses and appliances	506	498	8	0	8
Nursing-home care	7,650	3,571	4,079	234	3,845
Other health services	288	24	264	0	264
		Percent distribution			
Total	100.0	34.4	65.6	42.0	23.5
Hospital care	100.0	10.2	89.8	72.2	17.6
Physicians' services	100.0	40.9	59.1	54.1	5.1
Dentists' services	100.0	92.9	7.1	.0	7.1
Other professional services	100.0	49.8	50.2	38.0	12.2
Drugs and drug sundries	100.0	86.9	13.1	.0	13.1
Eyeglasses and appliances	100.0	98.4	1.6	.0	1.6
Nursing-home care	100.0	46.7	53.3	3.1	50.3
Other health services	100.0	8.2	91.8	.0	91.8
		Per capita			
Total	$1,360.16	$468.53	$891.63	.....	
Hospital care	602.89	61.75	541.14	.....	
Physicians' services	217.66	88.96	128.69	.....	
Dentists' services	24.17	22.45	1.72	.....	
Other professional services	19.74	9.83	9.91	.....	
Drug and drug sundries	117.68	102.30	15.38	.....	
Eyeglasses and appliances	22.65	22.29	.36	.....	
Nursing-home care	342.47	159.88	182.58	.....	
Other health services	12.89	1.05	11.84	.....	

APPENDIX II

Percentage distribution of persons by time interval since last dental visit according to sex and age: United States, 1977. (Data are based on household interviews of the civilian noninstitutionalized population.)*

Sex and Age	Total Population	Time Interval Since Last Dental Visit: Under 6 Months	6–11 Months	1 Year	2–4 Years	5 Years and Over	Never	Unknown
Both Sexes		Percent Distribution						
All Ages	100.0	35.7	14.1	13.1	12.9	13.9	9.3	1.1
Under 17 Years	100.0	36.6	14.4	10.5	6.5	1.6	29.5	0.8
17–24 Years	100.0	37.8	17.4	17.5	15.6	6.8	3.1	1.7
25–44 Years	100.0	37.8	15.7	16.2	16.0	12.0	1.2	1.1
45–64 Years	100.0	36.3	12.4	12.0	15.0	22.7	0.6	1.0
65 Years and Over	100.0	23.6	7.8	7.9	14.1	45.2	0.6	0.8
Male								
All Ages	100.0	34.3	14.0	13.3	13.3	13.9	9.9	1.2
Under 17 Years	100.0	36.1	14.2	10.3	7.1	1.7	29.4	0.8
17–24 Years	100.0	34.2	17.5	17.9	16.5	7.9	3.7	2.3
25–44 Years	100.0	35.5	15.3	16.1	16.8	13.5	1.5	1.3
45–64 Years	100.0	35.3	12.4	12.2	15.3	22.8	0.8	1.2
65 Years and Over	100.0	22.8	7.8	7.8	14.3	45.6	0.9	0.9
Female								
All Ages	100.0	36.9	14.2	12.9	12.5	14.0	8.7	0.9
Under 17 Years	100.0	37.2	14.7	10.3	6.0	1.5	29.5	0.8
17–24 Years	100.0	41.2	17.3	17.2	14.7	5.7	2.7	1.2
25–44 Years	100.0	39.9	16.1	16.4	15.3	10.5	1.0	0.9
45–64 Years	100.0	37.2	12.4	11.9	14.7	22.5	0.4	0.9
65 Years and Over	100.0	24.1	7.8	8.0	14.0	44.9	0.4	0.7

* National Center for Health Statistics, *Vital and Health Statistics*, Series 10, Number 126, Sept 1978.

APPENDIX III

TABLE ONE

Dental Health Habits and Attitudes of The Elderly (60 and Over)

	Total Elderly 60 and Older (n = 1283)	Men (n = 568)	Women (n = 715)
How satisfied are you with the general condition of your health?			
Very satisfied	33%	31%	35%
Fairly satisfied	42	45	40
Somewhat dissatisfied	18	18	17
Very dissatisfied	8	6	9
How satisfied are you with the present conditions of your teeth (or dentures) and gums?			
Very satisfied	48	44	51
Fairly satisfied	30	33	28
Somewhat dissatisfied	13	13	14
Very dissatisfied	9	11	7
Which of these best describes your present situation?			
All of my teeth are my own	16	11	20
I have partial dentures	27	32	23
I have full dentures	44	45	43
I am missing some teeth but have no dentures	11	10	12
Don't know	2	*	2
About how often do you go to the dentist?			
More than every six months	2	3	2
Every six months	18	15	20
Once a year	17	15	18
Every 2–3 years	5	3	6
Only when needed	48	53	44
Never	10	11	10
How much dental work would you guess you would accumulate during the next year?			
None	39	39	40
Would need routine checkup and cleaning	22	18	26
Would need to have some fillings	13	8	18
Would need more complicated treatment	12	15	9
Don't know	16	21	13
When was your last dental visit			
Less than 6 months ago	24	21	26
6 months–1 year ago	11	13	9
1 year–23 months ago	11	9	13
2 years–3 years ago	8	8	8
3 years or more ago	46	48	43
Never/Don't know	1	*	*
Which of the following best describes your present method of receiving dental care?			
Family dentist practicing alone	77	71	82
Family dentist in a group	16	18	14
Public dental clinic	4	8	*
Dental school clinic	*	*	*
Other/Don't know	*	*	*
What did the dentist do on this last visit?			
Examination and/or X-rays	40	47	34
Filling	28	27	29
Cleaning	56	48	63
Gum treatment	4	*	6
Extraction/oral surgery	14	25	5
Dentures	21	28	15
Straightening/tooth capped	*	*	*
Other/don't know	5	8	*
From this list, what are your main reasons for not going more often?			
I feel no need to go	79	76	81
I am unable to get appointment	*	*	*
I am waiting for insurance	*	*	*
I fear the pain	2	3	*
I think costs are too high	12	12	11
I have a transportation problem	3	*	4
Approximately how much did you personally spend for dental treatment in the last year, including any bills by an insurance company?			
Nothing	3	*	*
Less than $50	34	33	34
$50	9	12	6
$51–$99	14	15	12
$100	6	*	7
$101–$150	4	*	7
$151–$299	10	8	12
$300–$999	8	10	7
Has there ever been a time when you were seeking dental care and could afford it, but could not find a dentist to treat you?			
Yes, could not find dentist	11	13	10
No, has never happened	86	84	88
Don't remember/no answer	2	3	2
Has the amount you thought it would cost ever prevented you from seeking dental care you needed?			

*Percentage based on cell size less than 10.

Yes, cost prevented seeking needed dental care	21	16	25
No, it has not	77	81	74
Don't know/no answer	2	3	*
Have dental fees ever kept you from returning to complete a treatment?			
Yes, fees kept me from completing treatment	10	7	13
No, they have not	88	90	87
Don't know/no answer	2	3	*
If an unexpected $500 dental bill were to arise in your household, which of these would best describe your position?			
Able to pay comfortably without insurance	21	22	20
Able to pay comfortably with insurance	10	12	9
Able to pay but with financial difficulty	49	52	48
Unable to pay	19	13	23
Do you have health insurance that helps to pay your dental bills?			
Yes	10	11	9
No	87	87	88
Don't know/no answer	3	2	3
Do you think that all people are entitled to basic dental care, even if they cannot afford it?			
Yes	88	88	88
No	10	10	9
Don't know/no answer	2	2	3
Who do you think should pay for the dental work of the poor?			
Dentists should provide free dental care	4	2	5
Local or state taxes	23	24	22
Federal government taxes	56	57	54
Pay it themselves	13	12	14
Don't know/no answer	8	8	8

TABLE TWO

Frequency of Dental Visits of Persons Age 60 and Over by Oral Health Status and Income

	How Often Do You Go to the Dentist?					
Oral Health Status	Every 6 Months	Once a Year	2–3 Years	As Needed	Never	n
Have all own teeth	38.2%	32.2%	*	26.1%	*	(208)
Partials	39.4	25.2	*	32.1	*	(344)
Missing teeth but no dentures	19.8	16.1	14.4%	41.1	8.7%	(145)
Full dentures	2.4	6.2	3.8	69.5	18.0	(563)
Income						
Less than $7,000	13.4%	12.8%	4.4%	57.1%	12.2%	(863)
$7,000–$9,999	29.2	22.4	*	39.1	*	(139)
$10,000–$14,999	43.9	26.4	*	19.2	*	(99)
$15,000–$24,999	31.0	26.8	*	29.7	9.8	(107)
$25,000 or more	36.0	24.8	*	24.1	*	(73)

TABLE THREE

When Was Your Last Dental Visit—Persons 60 and Older

Income	Less Than 6 Months	6 Months–1 Year	1–2 Years	2–3 Years	3 Years or More	Never	n
Less than $7,000	16.7%	8.5%	9.4%	9.7%	54.6%	1.2%	(863)
$7,000–$9,000	31.0	13.9	14.5	5.5	33.7	1.4	(142)
$10,000–$14,999	47.6	13.0	11.5	2.6	24.2	1.0	(99)
$15,000–$24,999	36.9	23.4	13.8	*	25.0	*	(106)
$25,000 or more	42.7	*	20.0	*	19.7	*	(73)
Oral Health Status							
All own teeth	43.2%	15.2%	18.4%	*	22.3%	*	(208)
Partials	42.6	23.3	11.4	7.9%	14.5	*	(346)
Some missing teeth, no dentures	25.1	*	13.4	17.7	36.2	*	(145)
Full dentures	5.4	3.2	7.6	7.9	74.3	*	(564)

TABLE FOUR

Oral Hygiene Status of Persons Age 60 and Over

	All Own Natural Teeth	Partials	Missing Some	Full Dentures	n
Income					
Less than $7,000	13.7%	24.4%	10.4%	51.6%	(847)
$7,000–$9,999	26.2	24.6	11.5	37.7	(140)
$10,000–$14,999	25.3	28.1	21.9	24.7	(99)
$15,000–$24,999	17.6	42.1	12.9	27.5	(107)
$25,000 or more	16.6	46.0	7.9	29.6	(70)
Amount of Dental Care Needed					
None	8.5%	10.6%	7.0%	76.7%	
Routine checkup and cleaning	45.0	41.9	22.5	1.8	
Filling	24.9	23.9	22.3	*	
Complex treatment	12.9	16.7	27.4	4.4	
Don't know	15.5	13.2	21.5	17.0	
n	(208)	(345)	(554)	(142)	
Work Done at Last Dental Visit					
Exam/X-rays	41.1%	44.9%	49.0%	*	
Filling	34.8	28.9	35.7	*	
Cleaning	77.6	57.1	50.6	*	
Gum treatment	*	*	*	*	
Extraction/oral surgery	*	21.8	*	*	
Dentures	*	24.6	*	73.7	
n	(121)	(228)	(44)	(45)	

*Percentage based on cell size less than 10.

Fees Paid at Last Visit				
Less than $100	85.3%	81.8%	88.8%	96.6%
$100 or more	14.7	18.2	11.2	3.4
n	(208)	(346)	(145)	(564)
Reason For Not Going to a Dentist				
I feel no need to go	51.9%	74.3%	73.2%	90.7%
I fear the pain	*	*	12.8	*
I think the costs are too high	18.3	15.0	31.3	7.3
I have a transportation problem	*	9.3	*	*
Other	40.8	22.3	12.2	2.8
n	(76)	(112)	(98)	(496)

TABLE FIVE

Income of Persons Age 60 and Over by Dental Service Utilization

Treatment Received at Last Dental Visit	Income Less Than $7,000	$7,000–$9,999	$10,000–$14,999	$15,000–$24,999	$25,000 or more
Exam/X-rays	50.6%	26.6%	22.0%	39.1%	34.0%
Fillings	30.0	22.5	30.5	17.6	44.6
Cleaning	44.6	70.9	73.2	62.1	65.5
Gum treatment	*	*	*	*	*
Extractions/oral surgery	26.5	*	*	*	*
Dentures	25.5	*	*	31.8	*
Main Reason for Not Going to the Dentist					
I feel no need to go	83.2%	77.0%	94.9%	87.9%	67.8%
I think costs too high	12.5	14.4	*	*	*
I have a transportation problem	3.1	*	*	*	*
I have no time/ too busy	2.6	*	*	*	*
Other	12.0	19.0	19.0	22.0	36.0
Who Should Pay for Dental Care of Poor?					
Dentists provide free care	3.3%	*	*	10.6%	*
Local or state taxes	20.6	35.5%	23.2%	38.8	31.2
Federal government taxes	65.3	50.8	65.0	49.3	38.5
Poor pay themselves	12.7	14.7	14.4	13.9	29.7

*Percentage based on cell size less than 10.

APPENDIX IV: PUBLICATIONS AND PROGRAMS DEALING WITH DENTURISM

Both Sides of the Issue: Denturism: a document that reviews major arguments in support of and in opposition to denturism.

Denturism: An Historical Review: reviews history up through end of 1978.

Illegal Dentistry Lecturer Program: Coordinated by a public relations firm, places spokesmen to discuss significant aspects of denturism.

Importance of Complete Work Authorization Forms: a reprint from *The Journal of the American Dental Association*, Nov 1977.

Quarterly Compilation of National Newspaper Articles.

Access Programs: Limits and Liabilities: a "how-to" manual describing considerations which must be given to establishment of a dental access program.

Compendium of Reduced Fee Denture Techniques: a compilation of various clinical procedures employed to reduce the cost of denture service.

Legislative Testimony Manual: guidelines for preparation of legislative testimony on denturist-type bills.

Legislative Testimony: A Videotape: record of live presentation by a dentist of testimony for a legislative hearing.

Legislative Contact: Organizing a Legislative Contact System to Lobby Against Illegal Dentistry: includes a manual developed for use by "contact" dentists with assigned legislators and a manual prepared for state dental society officers that describes how to organize a statewide system in which individual dentists contact legislators.

Distribution of Denture Care Pamphlets: available pamphlets include: *Dentures, What You Don't Know Can Hurt You, Don't Do It Yourself, Your New Dentures, Immediate Dentures* and *Removable Partial Dentures.*

After-Care Guidelines: reprint from *The Journal of the American Dental Association*, June 1977.

PART V: THE HANDICAPPED, INSTITUTIONALIZED AND HOMEBOUND

Intent: This section discusses three groups within the population that are distinct in many ways but, with respect to dental care, share salient characteristics.

The primary barrier to access for these groups is the inability of many to travel to the usual sources of dental care which is, to some degree, complicated by general health conditions that make it more difficult to receive care and/or to cooperate with the dentist in the course of treatment.

Description of the Handicapped:[1] Handicapping is described as a chronic physical, mental or emotional condition that limits an individual's ability to perform activities appropriate to his or her age group.

Based on that definition, there are about 33 million persons in the United States—some 15% of the population—who can be identified as handicapped. Categorized by age, this includes about 4 million under the age of 18; some 18 million aged 18 to 64; and approximately 11 million who are 65 years of age or older. (See Figures One and Two.[2])

Of these 33 million people, about 2 million are institutionalized (half of these are 65 years of age or older); about 2 million are permanently confined to their homes; and another 2 million are so severely limited in self-mobility as to need special aids and/or another person to help them move about.

There seem to be no sharp distinctions with respect to handicapping based on age or sex. The percentage of handicapped does, however, tend to rise by ascending categories of age: about 3% of preschool children are handicapped; about 24% of those between the ages of 45 and 64; and about 40% of those over the age of 65.

More than 15 million Americans between the ages of 20 and 64 are unable to work because of totally disabling handicaps. It has been estimated that about 30% of the families in poverty have a member of the family who would normally be a wage earner, but who is handicapped to a moderate-to-severe degree.

About 60% of the nation's handicapped population live in urban settings and the remainder live in small communities or on farms. Appendix I lists a number of relevant handicapping conditions.[3]

Description of the Institutionalized: In a 1977 report from the National Institute of Mental Health,[4] some 2.1 million people were identified, as of 1970, as residing in institutions of various types. (The institutions listed exclude the general hospital population who are not included within the scope of this report.)

Of the 2.1 million people, the largest percentages were those in homes for the aged and dependent (43.6%); those in correctional institutions (15.4%); and those in mental hospitals and residential treatment centers (20.4%). Appendix II shows the detailed compilation.[5]

FIGURE ONE

THE HANDICAPPED AS A PERCENTAGE OF THE POPULATION, 1976

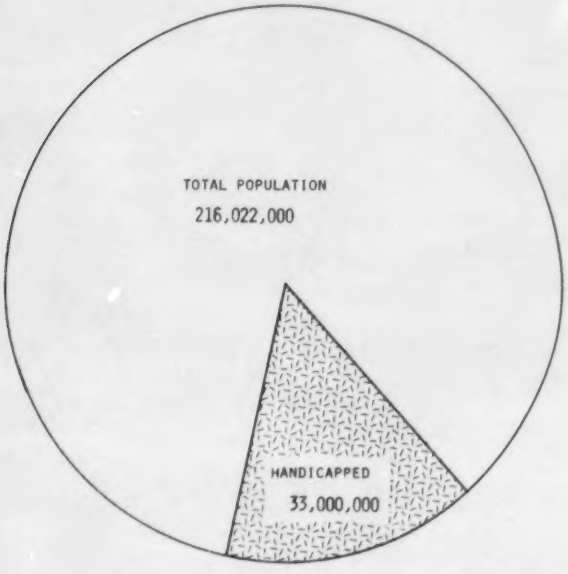
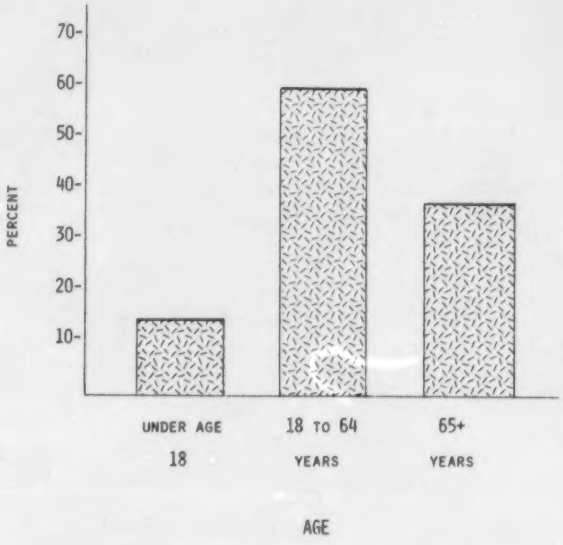


FIGURE TWO

PERCENT DISTRIBUTION OF THE HANDICAPPED, 1976



Description of the Homebound: In compiling this report, there was little success in obtaining current or authoritative estimates of the number of homebound. Data compiled between June 1966 and June 1968 indicated that, during that period, 1.7 million persons over the age of 55 were receiving health related home care.[6] This would not necessarily indicate that they were homebound for long periods of time, much less permanently. In 1977, the Congressional Budget Office issued an estimate that as many as 6.7 million people were receiving basic, long-term care in their homes.[7]

Utilization of Dental Services: There are few statistics available to trace a profile of dental care utilization by any of the groups being considered.

With respect to the handicapped, various studies report nearly universal periodontal disease—perhaps because of the high incidence related to Downs syndrome—as well as a high incidence of untreated carious teeth, missing teeth and significantly poorer oral hygiene when compared to control groups of the nonhandicapped. The handicapped who have received care show a higher proportion of extractions than do the nonhandicapped and also show evidence of less preventive or restorative care. Their access to care is complicated by the fact that 57% had family incomes in 1976 of less than $10,000.[8]

With respect to those living in the homes for the aged and dependent, now nearly 1 million people, a 1973 survey indicates that only 18% of nursing homes provide any type of dental service.[9] Further, a 1976 survey indicated that approximately 50% of the residents of nursing homes were confined either to their bed or to their room and fewer than 40% were able to leave the home even with assistance. More than 85% of nursing home residents are more than 65 years of age and nearly 70% are more than 75 years of age.[10]

Profession's Activities: With respect to the handicapped, the Association in 1977 began a relationship with the National Foundation of Dentistry for the Handicapped through an initial grant to the Foundation. That relationship had since been strengthened through further grants and by an invitation from the Foundation to the Association to place a representative on its Board of Directors.

In cooperation with the Foundation and other agencies, state dental societies have become more active in addressing the needs of the handicapped, especially the developmentally disabled. One example of such interest was a conference on Dentistry for the Developmentally Disabled sponsored in May 1979 by the Missouri Dental Association in conjunction with the Regional Dental Center of Iowa University. The conference was open to both dentists and their auxiliaries and its published proceedings provide a model of considerable value to other state dental societies.

The University of Washington School of Dentistry has, in recent years, been active in publishing a series of manuals on caring for disabled dental patients that could be advantageously used by dentists and dental societies throughout the nation.

With respect to the handicapped, institutionalized and homebound, the Board intends to take the following actions:

19. DEVELOP A PROGRAM TO PROVIDE ASSISTANCE AND INFORMATION TO STATE AND LOCAL SOCIETIES TO ASSIST DENTISTS IN CARING FOR HANDICAPPED AND DISABLED PATIENTS.

Rationale: Many disabled patients could come to the dental office if certain modifications and special assistance were provided within the office. Publications and pamphlets are available from the National Foundation of Dentistry for the Handicapped, the University of Washington and, undoubtedly, other agencies detailing structural changes necessary to accept wheelchair patients and instruction to the dental staff on assistance to the disabled patient. The Association will review available literature and distribute the most instructional to component dental societies. Dental societies will be encouraged to assist in assuring that at least one dental office in each community in the nation has the necessary facilities for care of handicapped and disabled patients. Some state dental societies, such as Massachusetts, already publish a directory of such offices as has the Women's Auxiliary of the Sacramento District Dental Society. These are superb models for all dental societies.

20. MAINTAIN SUPPORT OF THE NATIONAL FOUNDATION OF DENTISTRY FOR THE HANDICAPPED.

Rationale: A continuing relationship with the National Foundation of Dentistry for the Handicapped should enable the Association to assist in providing a broader series of programs for the handicapped. The Foundation currently has several projects addressing the needs of the handicapped, homebound and elderly. These projects include a "Campaign of Concern" preventive dentistry outreach program for the handicapped in several communities and a specially equipped van containing a mobile operatory and laboratory available to dentists serving nursing home residents and the homebound.

The Association will also act to inform constituent societies of these Foundation projects and similar undertakings by others and provide information to societies wishing to become more active.

Further, the Association and Foundation staff will work together in locating additional funding sources, both nationally and at the state levels.

21. IDENTIFY AND PUBLICIZE OTHER SOURCES OF CARE FOR THE HANDICAPPED, INSTITUTIONALIZED AND HOMEBOUND.

Rationale: Many local and state dental health depart-

ments are providing care to the handicapped, institutionalized and homebound. In addition, several constituent and component societies have developed pilot programs, as have other private agencies. The Association is presently compiling information on these programs and the populations served. This information will be codified and widely distributed.

22. DEVELOP A BETTER INFORMATION BASE ON THE DENTAL HEALTH NEEDS OF THE LONG-TERM HOMEBOUND.

Rationale: Too little is currently known about the dental health needs of the long-term homebound. Before program approaches can be pursued, additional information must be gathered and analyzed.

One possible method of accomplishing this would be a cooperative effort with the Visiting Nurses Association. A pilot project could be funded during which dental hygienists would accompany nurses on home visits for a given period of time sufficient to begin to learn the dimensions of the need. The Board believes, as well, that the Women's Auxiliary to the American Dental Association can provide a valuable resource in assisting the homebound, as well as other special groups, and its cooperation will be solicited.

23. HELP ESTABLISH APPROPRIATE CONTINUING EDUCATION FOR PRACTITIONERS AND COOPERATE WITH DENTAL EDUCATORS REGARDING ANY NECESSARY ADDITIONS TO THE UNDERGRADUATE AND POSTGRADUATE DENTAL SCHOOL CURRICULA.

Rationale: There are, the Board believes, many instances where a dentist would feel far more confident in caring for more handicapped patients if brief refresher courses were available to help answer any questions about such matters as office modification and patient management. The Board believes the Association should help in assuring that such courses are readily available.

The Board also wishes the House to know that the Association is cooperating in dissemination of the results of a recently completed project, funded by the Robert Wood Johnson Foundation, on teaching dental students to better manage the treatment of handicapped patients.

24. IMPLEMENT APPROPRIATE METHODS OF PROVIDING MORE ACCESSIBLE DENTAL CARE TO NURSING HOME RESIDENTS.

Rationale: In Vermont, the Association is presently carrying out a survey to determine dental needs of nursing home residents as well as the physical and psychological tolerance of residents to receive given types of care. It is expected that the results from this survey will prove most useful, by extension, to the national nursing home population.

At the same time, existing pilot projects—that use mobile vans or share portable equipment—will be reviewed for their contributions to a solution to this need.

Improvement in the existing Medicaid program and establishment of dental benefits under Medicare will, of course, prove most useful in helping nursing home residents to receive care.

Federal Medicaid language which allows nursing home residents to apply their income to necessary medical care before it is applied to the cost of their nursing home care will also be investigated. At least one state dental association has been successful in persuading the state to allow nursing home residents to use their available income to purchase dental care and another state is currently involved in litigation on the same question.

25. EXPLORE THE POTENTIAL FOR RESOLVING PROBLEMS OF LIMITED HEALTH MANPOWER AND CAPITAL RESOURCES IN NURSING HOMES.

Rationale: While efforts to provide resources for delivering care to nursing home residents are worthwhile and should be pursued, the dimensions of the nursing home problem may require stronger measures.

It is known that the majority of the nursing home population is elderly, poor, and has limited mobility and other overriding health problems. These personal characteristics, coupled with facility limitations of a financial and staffing nature, become severe barriers to the provision of dental care to nursing home residents. Medicaid, and potentially Medicare, only address the individual's financing problems, not capital financing for dental equipment, staffing and administrative costs.

References

1. *A Profile of the Handicapped Population of the United States*, Bureau of Economic and Behavioral Research, 1979.
2. *A Profile of the Handicapped Population of the United States*, Bureau of Economic and Behavioral Research, American Dental Association, 1979 and U.S. Department of Commerce, Bureau of the Census.
3. Snow, Hole and Stiefel, *A Profile of the Handicapped Population and Disabled Dental Patients: How Many?*, University of Washington School of Dentistry, 1977.
4 and 5. *Psychiatric Services and the Changing Institutional Scene*, Public Health Service (HEW), 1977.
6. *Home Care for Persons 55 Years and Over*, National Center for Health Statistics (HEW), 1972.
7. *Health, United States, 1978*, Office of the Assistant Secretary for Health, HEW, 1979.
8. *A Profile of the Handicapped Population of the United States.*
9 and 10. *Characteristics, Social Contacts and Activities of Nursing Home Residents*, Health Resources Administration (HEW), 1977.
11. *The Accessible Dental Office and Wheelchair Transfers in the Dental Office*, University of Washington School of Dentistry, 1977 and 1976.

APPENDIX I

(There are two categories into which handicapping conditions are often divided: developmental disabilities and medical disabilities. These can be further categorized, with some exclusions outside the scope of this section, as follows. The total exceeds 33 million because of overlapping conditions)[11]:

DEVELOPMENTAL DISABILITY

Condition	Estimated Number
Mental retardation	6.5 million, of whom about 5% are severely to profoundly retarded
Cerebral palsy	700,000, of whom some 20% are severely disabled; additionally, about 50% have some degree of associated mental retardation
Muscular dystrophy	220,000
Hearing loss to point of severe impairment	1.7 million
Vision loss to point of severe impairment	1.4 million

MEDICAL DISABILITY

Total paralysis	800,000
Rheumatoid arthritis	6 million
Diabetes	600,000 with major limitation
Seizure disorders (including epilepsy)	4.5 million from mild to severe
Multiple sclerosis	450,000
Sickle cell anemia	25,000
Emphysema	1.3 million
Renal failure	40,000
Mental illness	9 million
Cleft lip and/or palate	121,000

APPENDIX II: THE INSTITUTIONALIZED

Type of institution	Total		
	1950	1960	1970
	Number of persons		
Total all institutions	1,566,846	1,886,967	2,126,719
Correctional institutions	264,557	346,015	328,020
Mental hospitals & residential treatment centers	613,628	630,046	433,890
Tuberculosis hospitals	76,291	65,009	16,912
Chronic disease hospitals (excl. TB & mental)	20,084	42,476	67,120
Homes for the aged and dependent	296,783	469,717	927,514
Homes & schools for the mentally handicapped	134,189	174,727	201,992
Homes & schools for the physically handicapped	20,999	24,291	22,739
Homes for dependent & neglected children	96,300	73,306	47,594
Homes for unwed mothers	3,135	3,497	4,209
Training schools for juvenile delinquents	36,986	45,695	66,457
Detention homes	3,894	10,821	10,272
Diagnostic & reception centers	(N.A.) 3/	1,367	(N.A.) 3/
	Percent		
Total all institutions	100.0	100.0	100.0
Correctional institutions	16.9	18.3	15.4
Mental hospitals & residential treatment centers	39.2	33.4	20.4
Tuberculosis hospitals	4.9	3.4	0.8
Chronic disease hospitals (excl. TB & mental)	1.3	2.3	3.2
Homes for the aged and dependent	18.9	24.8	43.6
Homes & schools for the mentally handicapped	8.6	9.3	9.5
Homes & schools for the physically handicapped	1.3	1.3	1.1
Homes for dependent & neglected children	6.1	3.9	2.2
Homes for unwed mothers	0.2	0.2	0.2
Training schools for juvenile delinquents	2.4	2.4	3.1
Detention homes	0.2	0.6	0.5
Diagnostic & reception centers	(N.A.) 3/	0.1	(N.A.) 3/
	Number per 100,000 Population		
Total all institutions	1,035.4	1,052.3	1,046.6
Correctional institutions	174.8	193.0	161.4
Mental hospitals & residential treatment centers	405.5	351.3	213.5
Tuberculosis hospitals	50.4	36.3	8.3
Chronic disease hospitals (excl. TB & mental)	13.3	23.7	33.0
Homes for the aged & dependent	196.1	261.9	456.4
Homes & schools for the mentally handicapped	88.7	97.4	99.4
Homes & schools for the physically handicapped	13.9	13.5	11.2
Homes for dependent & neglected children	63.6	40.9	23.4
Homes for unwed mothers	2.1	2.0	2.1
Training schools for juvenile delinquints	24.4	25.5	32.7
Detention homes	2.6	6.0	5.1
Diagnostic & reception centers	(N.A.) 3/	0.8	(N.A.) 3/

1/ As of date of decennial census of 1950, 1960, and 1970.

2/ Source: U.S. Bureau of the Census: 1953, 1963, 1973.

3/ N.A. = Not Available

PART VI: REMOTE AREA RESIDENTS

Intent: This section discusses those Americans who live in remote areas of the country where a source of dental care is untypically distant.

The primary barrier to access is the geographic distance that must be traveled, coupled with the time spent in travel. It is this combination of time and distance that is generally most pertinent to the designation of an area as remote.

Description: In 1976, 69.3 million Americans were living in those areas designated by the Bureau of the Census as "non-urban."[1]

Regionally, the South with 35.4% nonurban residents and the North Central with 28.4% led the nation in the percentage of their total populations living in nonurban areas. Based on total population figures, the South contains nearly 33% of all nonurban residents.[2]

Of these 69.3 million people, some 61 million are white while the remainder are black or members of other minorities.[3]

In 1976 as well, approximately 9.7 million of the nonurban residents were poor. This is a 14.3% rate of poverty, somewhat higher than the 11.4% that applies to the national population (Figures One and Two[4, 5]).

Poverty determinations for nonurban areas, in dollar figures, are set somewhat lower than for the urban resident. In 1977, the nonurban figures ranged from $2,475 for an elderly individual to $8,708 for a family of 7 members.[6]

Finally, some 5.7 million of nonurban residents are 65 years of age or older. This is 8.3% of the total and is, thus, somewhat less than the percentage of elderly in the national population (10.7%).[5]

It is, then, this population segment of 69 million within whom are found nearly all remote area residents. There is, of course, no contention by anyone that the entire nonurban population lives in circumstances remote from dental care.

No detailed studies were found in preparing this Report that would demonstrate precisely how many people do live in remote area situations. The closest known approach is the existing federal mechanism for formal designation of medically and/or dentally underserved areas. While such designations have, more recently, begun to include special populations as well as central city residents, the present list is still heavily weighted toward nonurban areas.

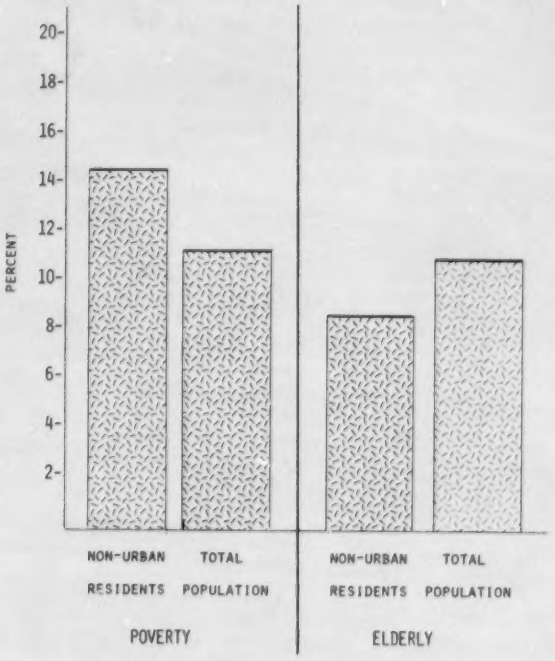
As of December 31, 1978, 631 areas within the nation had been designated as dentally underserved. The total population living within those 631 areas is 12.9 million. This is some 18% of the nonurban population and about 6% of the national population. Of the 631 areas designated as dentally underserved, 25% were areas in which there was no dentist. Cumulatively, the ratio of dentist to population for these designated areas is 1:7,000 (a total of 1,819 full-time equivalent dentists in the 631 areas). As of December 31, 1978, 200 dentists had been

FIGURE ONE

NON-URBAN REMOTE AREA RESIDENTS AS A PERCENT OF THE POPULATION, 1976

FIGURE TWO

NON-URBAN REMOTE AREA RESIDENTS BY LEVEL OF POVERTY AND AGE, 1976



placed in dentally underserved areas by the National Health Service Corps.[7]

Utilization of Dental Services by Nonurban Residents: The most recent statistics containing sufficient subcategorizations indicate that the *health care* behavior of nonurban residents is relatively similar to the national population but somewhat dissimilar with respect to *dental care* expenditures.

Appendix I,[8] which represents total out-of-pocket health expenses for 1975, for example, shows nonurban residents who had health expenses that year spending about 10% less annually than the national average. Appendix II,[9] which concentrates on dental expenditures, shows a difference of nearly 20%.

By the same token, when compared with the national population, fewer nonurban residents, by percentage, had no health expense during 1975 but more of them had no dental care expense.

Based on these statistics, then, there is some inference to be drawn that those living in remote areas, compared with the national population, include a slightly lower percentage of elderly; experience a slightly higher degree of poverty; are disproportionately located in the South and the North Central regions; are mostly white; and tend to have lower dental utilization rates.

Based on the federal mechanisms now used to designate dentally underserved areas, some 6% to 8% of the national population live in remote areas. Stated the other way, the present system geographically reaches out to more than 9 out of 10 Americans, which is a remarkable achievement.

Association Efforts: The Association has undertaken a variety of programs of assistance to residents of remote areas. The tempo of activity has increased in recent years.

Present policy includes a call to encourage dentists "to practice in underserved areas through federal financial incentives including guaranteed loans and tax benefits."[10] It also includes a statement on the National Health Services Corps that reads, in part, "The American Dental Association recognizes the concept of the National Health Services Corps as a temporary method for making dental services available in areas without sufficient dental manpower and where additional private practitioners are not available . . ."[11]

Additionally, the Association has recently undertaken cooperative funding of a Health Professions Placement Network that will afford communities seeking dentists, and dentists seeking practice locations, to have a central, computerized source of mutual reference. The Association, in supporting the Network, has directed that all federally designated underserved areas be entered into the System. Finally, the Association's Dental Planning Information System has capabilities for assisting regions and states to better assess the present and future needs of the population for given numbers of dental personnel.

With respect to remote area residents, the Board intends to take the following actions:

26. REEXAMINE EXISTING ASSOCIATION POLICY RESPECTING THE NATIONAL HEALTH SERVICE CORPS AND PROGRAM ACTIVITY.

Rationale: The Association's current policy with respect to the National Health Services Corps is, as noted, a recognition of "the concept . . . as a temporary method. . . ."

Given the fact that about 6% of the population lives in areas now designated as dentally underserved and the fact that more than 150 such areas have no dentist whatever, the Board believes it timely to explore whether a concept such as the Corps is, in all instances, merely "a temporary method." There may be reasons to believe that some areas may never be able to support a private practice, therefore, these areas may need to be supplied by some entity.

The difficulties the Association now has in its policy view of the Corps are, to some degree, related to the basic legislation and, in other ways, to the attendant regulations. The change in emphasis to populated areas where dentists are already present is not sensible in its present form. The gradual exclusion of the profession from a significant advisory role is unacceptable. The Board, further, has substantial doubts as to whether tying loan funds to dental students to Corps service is in the public interest.

At the same time, the need to seek changes in regard to such matters cannot blind us to the fact that there are people who live in remote areas who need dental care and who are entitled to have reasonably convenient sources for such care. Our opposition to unacceptable provisions of the current law should not be allowed to obscure from the public our positive interest in extending the reach of the dental care delivery system. This positive interest is documented by the fact that the vast majority of rural designations were fully supported by the local and state dental societies.

While no conclusions can be reached without further exploration by Association Councils and Bureaus, the Board believes the Association may wish to take the initiative in having introduced into Congress a bill that would replace the present legislation and would be better designed to solve the unquestionable problems that do exist.

Such legislation might, for example, allow cooperative exploration by the federal government and the profession of the criteria by which areas are designated as being underserved. It might also involve pilot projects that would clarify the conditions under which a Corps site has the potential for being transformed into a private practice site as distinct from conditions where such a change is unlikely.

Such an approach might investigate if a program of low interest loans—for practices in areas where the potential for private practice seems present—might serve better than the current policy calling for general tax credits and loans. The role of the Small Business Admin-

istration in carrying out loan programs could also be investigated in this regard.

27. CONTINUED SUPPORT OF THE HEALTH PROFESSIONS PLACEMENT NETWORK.

Rationale: The national expansion of the effort, begun in Minnesota, to identify communities needing dentists and link them to dentists seeking locations is a positive indication of the Association's interest in the oral health of remote area residents. The Association has already, in conjunction with the W. K. Kellogg Foundation, invested heavily in establishment of the Health Professions Placement Network. The structure of the Network is such that it is expected to be essentially self-sustaining within three years. When that happens it will virtually eliminate the need for the Association to directly subsidize its operation. There will be, however, a variety of ways in which the Association will wish to continue to support the concept; publicize its effects; study the reasons for its impact; and seek to have it play a prime role in national policy with respect to remote area residents.

28. CONTINUED SUPPORT OF THE DENTAL PLANNING INFORMATION SYSTEM TO ENHANCE ITS ABILITY TO PROVIDE INFORMATION ON CARE DELIVERY IN REMOTE AREAS.

Rationale: The Dental Planning Information System (DPIS), begun in 1973, is rapidly maturing. It is proving to be, as was hoped, a valuable planning tool for decision-makers outside the profession—as well as for the profession itself—in determining present and future needs for manpower in states and in substate regions. The Board fully expects its value to increase, especially with respect to productivity measures and on the mix of dentists and auxiliaries best suited for the particular needs of a community. Coupled with this are additional possibilities for exploring why, for example, nonurban residents have a lower utilization rate of dental services—when compared with the general population—than they do for medical services. Whatever the reasons—which may simply be the fact that nonurban residents have a slightly higher rate of poverty or the more elective nature of many dental services—they need to be taken into account when planning is being done.

29. COOPERATE MORE CLOSELY WITH DENTAL HEALTH DEPARTMENTS IN STATES WITH A HIGH NUMBER OF REMOTE AREA RESIDENTS INCLUDING POSSIBLE FUNDING OF DEMONSTRATION PROJECTS.

Rationale: Dentists involved in public health efforts in states with high numbers of remote area residents have wrestled with various solutions for some time. These include the use of mobile vans, contract dentists and satellite offices. In the view of the Board, these members of the profession constitute a valuable resource and their advice should be more actively sought. In doing so, the Board would commit itself to consider funding, on a demonstration basis, projects embodying solutions that seem to have a particular relevance and practicality. This will be carried out in conjunction with the constituent dental societies involved.

References

1. *Personal Out-of-Pocket Health Expenses*, National Center for Health Statistics (HEW): Vital and Health Statistics, Series 10, Number 122, Nov 1978.
2. *The World Almanac, 1979*, Bureau of the Census Report, pp. 205–261.
3. *The World Almanac, 1979*.
4. *Poverty Isn't Where It Used to Be, The National Journal*, pp. 349–351, March 3, 1979.
5. *The Elderly: A Socioeconomic Profile*, Bureau of Economic Research and Statistics, American Dental Association, 1977.
6. *Current Population Reports*, Bureau of the Census, Series P–60, No. 116, July 1978.
7. National Health Services Corps.
8. *Personal Out-of-Pocket Health Expenses*.
9. *Personal Out-of-Pocket Health Expenses*.
10. *Transactions, 1976*, American Dental Association, p. 849.
11. *Transactions, 1976*, American Dental Association, p. 849.

APPENDIX I

Age-adjusted* percent distributions of persons by intervals of total annual out-of-pocket *health expenses including health insurance premiums*, age-adjusted* average expense for persons with expense and per capita expense, according to selected characteristics: United States, 1975. (Data are based on household interviews of the civilian noninstitutionalized population.)**

Characteristic	Total Population in Thousands	Health Expense: No Expense	Less Than $50	$50-99	$100-249	$250-499	$500 or More	Average for Persons with Expense	Per Capita
		Percent Distribution						Expense in Dollars	
Total***	210,109	14.2	13.5	14.6	28.8	17.4	11.6	285	245
Place of Residence									
SMSA	141,885	15.0	12.7	14.3	28.3	17.4	12.3	291	253
Central city	62,156	19.4	12.9	13.3	26.2	16.3	11.9	300	251
Not central city	79,729	11.6	12.6	15.0	29.9	18.3	12.6	283	254
Outside SMSA	68,224	12.6	15.1	15.3	29.8	17.2	10.1	255	226
Geographic Region									
Northeast	47,733	15.9	12.2	14.4	29.6	16.9	11.0	279	240
North Central	56,993	13.2	15.4	16.7	28.5	16.7	9.3	241	212
South	68,247	13.4	12.4	13.7	28.7	18.8	12.9	304	269
West	37,136	14.9	13.9	13.1	28.4	16.4	13.4	292	254

*Adjusted by the direct method to the age distribution of the total civilian noninstitutionalized population of the United States.

**National Center for Health Statistics, *Vital and Health Statistics*, Series 10, Number 122, Nov 1978. (This publication also provides expense data by sex, family income, race and education of family head.)

***Includes unknown income and education.

APPENDIX II

Percent distributions of persons by intervals of annual out-of-pocket *dental expense*, average expense for persons with expense, and per capita expense, according to selected characteristics: United States, 1975. (Data are based on household interviews of the civilian noninstitutionalized population.)*

Characteristic	Total Population in Thousands	DENTAL EXPENSE: No Expense	Less Than $50	$50-99	$100-249	$250-499	$500 or More	Average for Persons with Expense	Per Capita
		Percent Distribution						Expense in Dollars	
Total**	210,109	58.2	23.3	8.1	6.2	2.6	1.6	99	41
Place of Residence									
SMSA	141,885	56.6	23.0	8.7	6.8	2.9	1.9	107	47
Central city	62,156	61.5	19.9	7.7	6.2	2.9	1.9	115	44
Not central city	79,729	52.6	25.5	9.5	7.4	3.0	1.9	102	48
Outside SMSA	68,224	61.5	23.8	6.9	4.9	1.9	0.9	80	31
Geographic Region									
Northeast	47,733	56.0	22.4	10.0	6.7	3.0	1.8	109	48
North Central	56,993	56.1	27.9	7.4	5.1	2.3	1.2	79	35
South	68,247	61.4	21.8	7.2	5.8	2.4	1.5	99	38
West	37,136	58.6	19.9	8.5	8.0	3.0	2.0	118	49

*National Center for Health Statistics, *Vital and Health Statistics*, Series 10, Number 122, Nov 1978. (This publication also provides expense data by sex, family income, race and education of family head.)

**Includes unknown income and education.

PART VII: THE UNINSURED WORKER

Intent: This section of the report discusses that percentage of the work force who do not presently have group dental prepayment coverage.

Properly speaking, this group of people cannot be said to be facing a barrier to access. Rather, the thrust of this section is to explore ways of enhancing their present high degree of access. They are included in the report because of their numbers and because of the demonstrated potential for private group dental prepayment to encompass effectively ever larger segments of the total population.

Description:[1] Based on 1976 figures, the American work force included approximately 93 million people. Of this total, about 78 million held full-time employment either as a wage earner or as self-employed. The remaining 15 million held part-time employment. Together with young dependents and nonworking spouses, this group essentially constitutes the total population of the nation. Their characteristics with respect to race, age (except for those more than 65 years of age), sex, income, and utilization of general health services and of dental services are those that pertain to the total population and, accordingly, are not reported here.

Present Extent of Nondental Health Insurance Coverage: It is estimated that, as of 1978, more than 90% of all Americans had either private health insurance or were eligible for public programs covering health care expenses. Generally speaking, those without coverage were the unemployed (27% of whom are without coverage) and those in the lower-income categories whose earnings are more than the levels stipulated for public programs.

Of the 90% with coverage, an estimated 77% have private insurance carriers.

Adequacy of coverage varies to a considerable degree. However, the vast majority were insured against inpatient hospital care and surgery and had some level of major medical benefits. Approximately half of those with private coverage had a plan with a uniform coinsurance feature and nearly three-fourths had a policy with a deductible of less than $100.

Private coverage for health care varies somewhat by industry but in only two instances is the coverage of the work force in an industry less than 80%. These exceptions are personal services, where 74% have coverage, and agricultural-forestry-fisheries, with 72% having coverage.

Present Extent of Dental Prepayment Coverage: It is presently estimated that some 60 million Americans have dental group prepayment coverage.[2] Of these, some 26 million would be the members of the work force through which prepayment is obtained. Within the work force,

then, there are some 67 million people who have some degree of health insurance but do not have dental prepayment coverage.

For the purpose of this paper, dental prepayment plans will be defined as any privately sponsored programs and any publicly sponsored programs for municipal, state or federal employees "in which periodic, specified payments (premiums, dues, or employer contributions) are made in advance and used to pay for dental services as the need arises." This definition is essentially the same as the one used by the Department of Health, Education, and Welfare, Division of Dentistry, in its *Survey of Dental Benefit Plans* (except for the inclusion of publicly sponsored plans for government employees). Included within this definition are conventional dental prepayment plans, self-insured plans, medical rider plans, Health Maintenance Organizations, closed panel arrangements and arrangements in which direct care is provided by the sponsors through in-plant facilities or clinics.

A prepayment plan may be financed through payments by individual enrollees, a consumer group, an employer, a governmental agency, a union-employer welfare and pension fund or any combination thereof. Payments for services may be made to the dentist or as a reimbursement to the patient. Excluded from this definition and this report are dental benefits provided through public welfare programs or to the military. Today such plans as are included in this report number more than 40,000.[3]

Several private and governmental agencies now collect data relating to dental prepayment plans: the HEW Division of Dentistry; Social Security Administration; the Bureau of Labor Statistics and the Labor Management Services Administration of the U.S. Department of Labor; the Health Insurance Association of America; Delta Dental Plans Association; and Blue Cross/Blue Shield. Although these agencies gather a tremendous volume of useful information, the information gathered is not presently structured or released in a form showing breakdowns of insured workers by industry, type of employment, union membership or state. The Division of Dentistry in its 1973 *Survey of Dental Benefit Plans* was unable to report results on several variables due to high nonresponse rates.

Surveys conducted by the Division and other agencies do, however, provide some clues as to where the future growth of prepayment plans may lie. Some of the more significant trends that have been identified are:

1. *Increase in the proportion of plans initiated by decision of management to expand fringe benefits and decline in the proportion of collectively bargained plans:* The Division's 1973 *Survey* reports that, prior to 1965, fewer than one-third of responding plans were initiated by management as a fringe benefit. Of those plans implemented in 1973, however, almost two-thirds attributed their dental plan to a management decision to expand fringe benefits. Conversely, more than half of the respondents with plans predating 1965 said they had collectively bargained for dental benefits; by the early seventies, however, this proportion changed and only a fifth of the respondents with plans originating in 1972 or 1973 said they had collectively bargained for dental benefits. This trend may be explained in part by the fact that the unionized percentage of the work force is about 20% of the total and unions were early in pushing for prepayment coverage;

2. *Increase in the proportion of plans with smaller membership and decrease in the proportion of plans with larger membership:* The Division's 1973 *Survey* found that, of plans predating 1965, 40% cover 500 or more principal members while less than 10% cover fewer than 25 subscribers. In contrast, the 1973 *Survey* reports that 60% of responding plans had fewer than 100 members and 25% had fewer than 25 members. Only 10% to 15% reported coverage of as many as 500 members. This, too, may relate to the degree to which the large corporations were earliest in the movement toward dental prepayment and that segment of the market is now relatively saturated;

3. *Large areas of the U.S. still have few dental plans while other areas appear to have large-scale coverage:* The Division's 1973 *Survey* reports extremely uneven distribution of plans throughout the various regions of the country. For example, nearly half of all dental plans are based in the Pacific Census Division (California, Washington, Oregon, Alaska, Hawaii), while the Mountain, West South Central and East South Central divisions have 2%, 1% and 1% of all plans, respectively. Some suggest that the distribution of plans reflects the industrial dispersion of the U.S.[4]

An increase in insured workers, then, must take the following trends into account:

1. A desire by companies to put dental prepayment in employee benefits packages in order to stay competitive with their peers. Within a particular industry there may be a snowballing effect when "lead" companies—as such exist—initiate a dental plan;

2. Real growth in dental plans during the next few years is likely to occur among medium and small employers and among intrastate rather than nationally based groups; and

3. Outside the Pacific region, the remainder of the country has a significant potential for growth.

In addition, future growth in the prepayment arena should take into account other identifiable categories of people who do not fit the conventional prepayment model. By and large, these groups do not presently have dental benefits. They include:

1. *Federal Employees:* With but a few exceptions, the 2.1 million people who are civilian federal

employees do not have dental prepayment coverage. They could obtain dental benefits through passage of federal legislation mandating such benefits or through union negotiations with the Civil Service Commission.

2. *Retirees:* Although several plans—United Auto Workers, Kodak and the communications industry are three examples—provide for benefits through retirement, the vast majority do not. The 1973 *Survey* found that only 6% of responding plans included provisions for retirees. Some 20 million Americans are retired.

3. *Self-employed:* There are about 3 million self-employed. They, their employees and dependents have little access to dental benefits.

4. *Non-employee Associations:* In the absence of individual insurance, millions of working Americans who do not receive dental benefits through employment theoretically might enjoy benefits through membership in service and/or volunteer organizations.

In forecasting the rapidity with which dental prepayment coverage will increase, some obvious barriers need to be taken into account.

One is the state of the economy in conjunction with the cost of dental prepayment coverage. Though the level of benefits—and therefore premiums—differs, a plan with comprehensive benefits and no deductible today costs at least $300 per year per worker for a large group. In an uncertain economy, this is a considerable cost.

A second barrier could well be the degree to which the public in general considers dental care to be of secondary importance and would press for fringe benefits covering other areas of need.

The level of knowledge about dental prepayment is still not high nor is there, as yet, broad experience with enrollment except through the work place.

The continuing lack of individual plans and the present unawareness of convenient options for the very small employee group are additional hindrances.

Association Activities: Through its Council on Dental Care Programs, the Association has established itself as a credible and influential source of information about dental prepayment. Attached, as Appendix I to this section of the Report, is the Council's description of the role it plays.

In addition to these Council activities, the Bureau of Health Education and Audiovisual Services is conducting a pilot project which, if implemented widely, might have some positive effect on the growth of dental prepayment. The project involves dental health education in the work place. Its object is to test whether behavioral changes can be achieved through health education in this setting. The Bureau of Economic and Behavioral Research has, as well, been involved in studies dealing with prepayment and its effects.

With respect to the nation's uninsured workers, the Board intends to take the following actions:

30. EXPANSION OF THE ASSOCIATION'S PRESENT ROLE IN STIMULATING THE GROWTH OF DENTAL PREPAYMENT.

Rationale: If the Association's mission during the next few years is to improve every American's opportunity to seek regular dental care, then it follows that the Association has a keen interest in the future growth of dental prepayment. The Association, of course, is not the only organization interested in stimulating such growth. Delta, the commercial insurance industry, and Blue Cross/Blue Shield also have an obvious interest in expanding the market. Taken together, they employ a considerable sales force and, as well, have a substantial amount of funds available for national advertising.

The Board believes it would be inappropriate, legally undesirable and too costly for the Association to attempt to become a *marketing agency* for dental prepayment. Instead, it believes the Association should consider prudent expansion of its current role in stimulating the growth of dental prepayment through educational campaigns aimed at the public and at potential purchasers.

In planning future activities appropriate Association agencies will consider the following:

An educational campaign to create greater public awareness of and demand for dental prepayment. Such a campaign might include institutional advertising in both statewide and national media, as well as a total communications plan at both levels.

Intensification of current contact programs to interest companies and other groups in dental prepayment. Presently, the Council on Dental Care Programs sponsors a national level contact program and provides training to prepare constituent society representatives for state level contact programs. These programs might be intensified, keeping in mind that the Association does not intend to sell insurance but simply to educate about the concept of dental prepayment.

31. BROADEN SOURCES OF PREPAYMENT COVERAGE BEYOND THE WORK PLACE.

Rationale: To date, dental prepayment plans have been underwritten primarily for employee groups in the traditional work place. Yet millions of working Americans—many of them self-employed—simply do not fit into traditional sources of coverage. In the absence of dental plans for individuals, they have little or no access to dental prepayment.

It is estimated that some 3 million Americans are self-employed. These individuals, their employees and dependents have not been cultivated as a potential source of growth in the dental prepayment market. One way to insure these groups may be through their occupational and professional associations. The Board, therefore, will request the appropriate agencies to explore with such associations, and with carriers, their interest in developing prepayment plans for these groups.

In addition to occupational and professional associations, other uninsured individuals theoretically could receive dental prepayment benefits through membership in service and/or volunteer organizations. Some examples of such groups might include the American Association of Retired Persons (AARP), with 12 million members, and the Parent and Teachers Association, with 6 million members. The Council on Dental Care Programs already has contacted the AARP about this possibility and plans to continue its liaison with this group in the future.

The Board is well aware of the perceived risks involved in insuring voluntary groups, especially the problem of adverse selection. Many carriers are reluctant to insure voluntary groups because of their adverse financial vulnerabilities in such situations. However, several dental prepayment plans have been successfully underwritten for smaller voluntary groups. In order to stimulate interest in the voluntary market, particularly the large voluntary groups, the Association may wish to explore the interest of carriers and voluntary associations in a demonstration program. If such a demonstration were feasible, the Association might also explore the interest of private foundations in providing seed money for the project.

32. SUPPORT EXTENSION OF GROUP DENTAL PREPAYMENT BENEFITS TO FEDERAL EMPLOYEES AND MILITARY DEPENDENTS.

Rationale: With but a few exceptions, some 2 million people who are civilian federal employees do not have dental prepayment coverage.

Currently, a bill to mandate dental benefits for federal civilian employees is in preparation with Association assistance and is expected to be introduced into this Congress. Federal civilian employees are one of the largest employee groups in existence today without dental prepayment coverage. When hearings are held on legislation to mandate such benefits, the Association will testify in full support of an appropriately drawn bill. At the same time, the Association will provide assistance to the federal employees union in its negotiations with the Civil Service Commission for dental benefits. The same actions will be taken with respect to military dependents. Association support of legislation in this area will be based on the consistency of the legislation with Association policy.

It is important to note that many state and municipal employees also are without dental benefits. Their options for obtaining such benefits are generally the same as those for federal workers.

33. WORK WITH PRIVATE AND GOVERNMENTAL GROUPS IN DEVELOPING A MORE DETAILED BASE OF INFORMATION ON DENTAL PREPAYMENT.

Rationale: If the Association chooses to expand its present role with regard to dental prepayment, development of a more detailed information base will be essential. Clearly, any efforts by the Association to stimulate the growth of dental prepayment will require more refined market information. Even if the Association continues in just its present role, such information might be extremely useful to third parties, health planners and government agencies. The Board believes, therefore, it would be advantageous for the Association to work with all interested private and governmental groups in developing a more detailed information base on dental prepayment.

References

1. Factual information in "Description" and "Present Extent of Non-Dental Health Insurance Coverage," except where otherwise noted, is from *Profile of Health Care Coverage: The Haves and Have-Nots*, Congressional Budget Office, 1979. Additional information is in a paper, "Dental Characteristics of the Uninsured," Bureau of Economic and Behavioral Research, American Dental Association, 1979.

2. Council on Dental Health Programs, American Dental Association.

3. Verbal communication from Division of Dentistry (HEW).

4. *Survey of Dental Benefits Plans, 1973.* Department of Health, Education, and Welfare, Health Resources Administration, Bureau of Health Manpower, Division of Dentistry, p. 7.

APPENDIX I: PREPAYMENT ROLE OF THE COUNCIL ON DENTAL CARE PROGRAMS

Purpose: To provide the several entities involved in dental prepayment in the private sector with the viewpoint of the dental profession, in order to improve the responsiveness of private dental benefits programs to the needs of patients. This objective is accomplished, primarily, through:

(a) liaison with prospective purchasers, policyholders, brokers and carriers involved in dental benefits programs;
(b) cooperation with constituent dental societies and individual practicing dentists to inform them of dental prepayment concepts and activities and to assist them in dealing with dental prepayment in their states and practices.

Following is an overview of some of the Council's more recent and ongoing activities:

Widely Publicized Information Services: Availability of the Council's information services is widely publicized through articles and advertisements in trade journals for benefits managers and union leaders. The ads include a self-addressed coupon for an information kit. Respondents to the ads receive the kit and information on the Council's consultation services. Names of intrastate employers who respond to the ad are referred to appropriate constituent societies.

Constituent Society Workshops: In view of the potential for growth in the intrastate market, the Council last year began conducting workshops to educate constituent societies about the structure of dental benefits plans and liaison approaches to prospective purchasers.

Special Training Sessions for Constituent Representatives: As a follow-up to the workshops for constituents, the Council conducts special training sessions on communications skills for state society representatives who eventually will provide consultation services to prospective intrastate purchasers.

Consultation Services: Council staff and members provide ongoing consultation services to both prospective purchasers and policyholders at the national level.

Liaison with Information Gatherers: The Council maintains close liaison with various agencies and associations that gather data on prepayment plans: The HEW Division of Dentistry, the Social Security Administration, the Health Insurance Association of America, Delta Dental Plans Association and Blue Cross and Blue Shield Associations. In addition to monitoring data published by such organizations, the Council coordinates estimates on total number of beneficiaries covered by dental prepayment, reviews survey instruments, and provides various other services to information gatherers.

Exploratory Steps Regarding Potential Unconventional Purchasers: Investigation of the concept of prepayment coverage of groups outside the employment setting is a new Council priority. During the past year, the Council has established liaison with the American Association of Retired Persons to explore their interest in sponsoring a dental prepayment plan, and it will be doing the same with similar groups in the future. In addition, it recently mailed a query to insurers concerning any voluntary plans they carry. Eventually, the Council hopes to be able to provide prospective purchasers of voluntary plans information on carriers who are willing to underwrite such plans.

PART VIII: CONCLUSION

With the advice of the House, then, the Board will undertake immediately this program of prevention and control of dental disease through improved access to comprehensive care. In doing so, the Board will, as always, rely heavily on the leadership and initiative of those Association agencies whose *Bylaws* give them special responsibility for the framing of these specific activities.

It is the Board's belief that the resources of the Association are such as to permit launching the program now in a carefully coordinated way and on a broad scale. In addition to beginning the program itself, the Board fully intends to make use of the Association's communications arm to let the nation know what the dental profession is doing.

Each of the 33 actions listed in this Report are essential to the program. It would not be useful to attempt a strict listing of them in sequential priority for a variety of reasons. In the first place, many of them can begin simultaneously through the efforts of various Councils and Bureaus. Indeed, many are already underway to some degree. Secondly, the way in which the total program will be managed over the coming years—for this is clearly a long-term effort—will partly depend on what else is happening throughout the nation. The Association, of necessity, must be sufficiently flexible to shift program emphasis in light of such changes.

In reviewing the 33 actions, however, the Board believes there are two categories of possible action. Some of the items are broad, fundamental thrusts of the Association while the second type is more directed to specific aspects of an activity.

The summary recommendations are listed in sequence as presented in the report.

SUMMARY OF RECOMMENDATIONS

1. Increase Association efforts to promote the concepts of prevention within the profession and the public sector, including government.
2. Draw freely on the special professional abilities of dentists who are expert in practice, in public health, in research and in education.
3. Actively seek allies throughout society on specific activities that will help improve access to care for all.
4. Maintain and coordinate council and other Association activities involved in this program.
5. Maintain quality dental care in all aspects of the delivery system.

6. Seek new ways for the Association to assist state and local dental health units to strengthen themselves.
7. Speak clearly to the public and to government about their respective responsibilities with respect to dental health.
8. Recognition that the traditional form of private practice will remain the major source of dental care coupled with an understanding that other sources of care exist and should receive objective attention.
9. Press for more efficient administration of and more equitable reimbursement under Medicaid and similar programs.
10. Intensify efforts at the federal level to mandate basic dental benefits for all Medicaid recipients.
11. Explore the funding of a pilot project to obtain broader Medicaid dental care benefits at the state level.
12. Explore the use of elementary and secondary schools in providing patient education, referral and oral prophylaxis dental services to children.
13. Emphasize comprehensive dental services in addressing the need of the elderly.
14. Intensify efforts to amend Medicare to include dental benefits.
15. Seek ways to extend private group dental prepayment benefits to the elderly.
16. Develop minimal criteria that state dental societies must take to be eligible for Association assistance to provide access programs for denture care.
17. Investigate ways to improve increased opportunity for dental care for the elderly through a greater availability and effective utilization of dentists and dental auxiliaries.
18. Establish a national organization concerned with the dental health of the elderly.
19. Develop a program to provide assistance and information to state and local societies to assist dentists in caring for handicapped and disabled patients.
20. Maintain support of the National Foundation of Dentistry for the Handicapped.
21. Identify and publicize other sources of care for the handicapped, institutionalized and homebound.
22. Develop a better information base on the dental health needs of the long-term homebound.
23. Help establish appropriate continuing education for practitioners and cooperate with dental educators regarding any necessary additions to the undergraduate and postgraduate dental school curricula.
24. Implement appropriate methods of providing more accessible dental care to nursing home residents.
25. Explore the potential for resolving problems of limited health manpower and capital resources in nursing homes.
26. Reexamine existing association policy respecting the National Health Service Corps and program activity.
27. Continued support of the Health Professions Placement Network.
28. Continued support of the Dental Planning Information System to enhance its ability to provide information on care delivery in remote areas.
29. Cooperate more closely with dental health departments in states with a high number of remote area residents including possible funding of demonstration projects.
30. Expansion of the Association's present role in stimulating the growth of dental prepayment.
31. Broaden sources of prepayment coverage beyond the work place.
32. Support extension of group dental prepayment benefits to federal employees and military dependents.
33. Work with private and governmental groups in developing a more detailed base of information on dental prepayment.

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